Collège National des Cardiologues des Hôpitaux

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SESSION: RECOMMANDATIONS NSTEMI

Quoi de neuf pour les antithrombotiques ?

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@CuissetDr

Avec le soutien institutionnel des laboratoires

AstraZeneca

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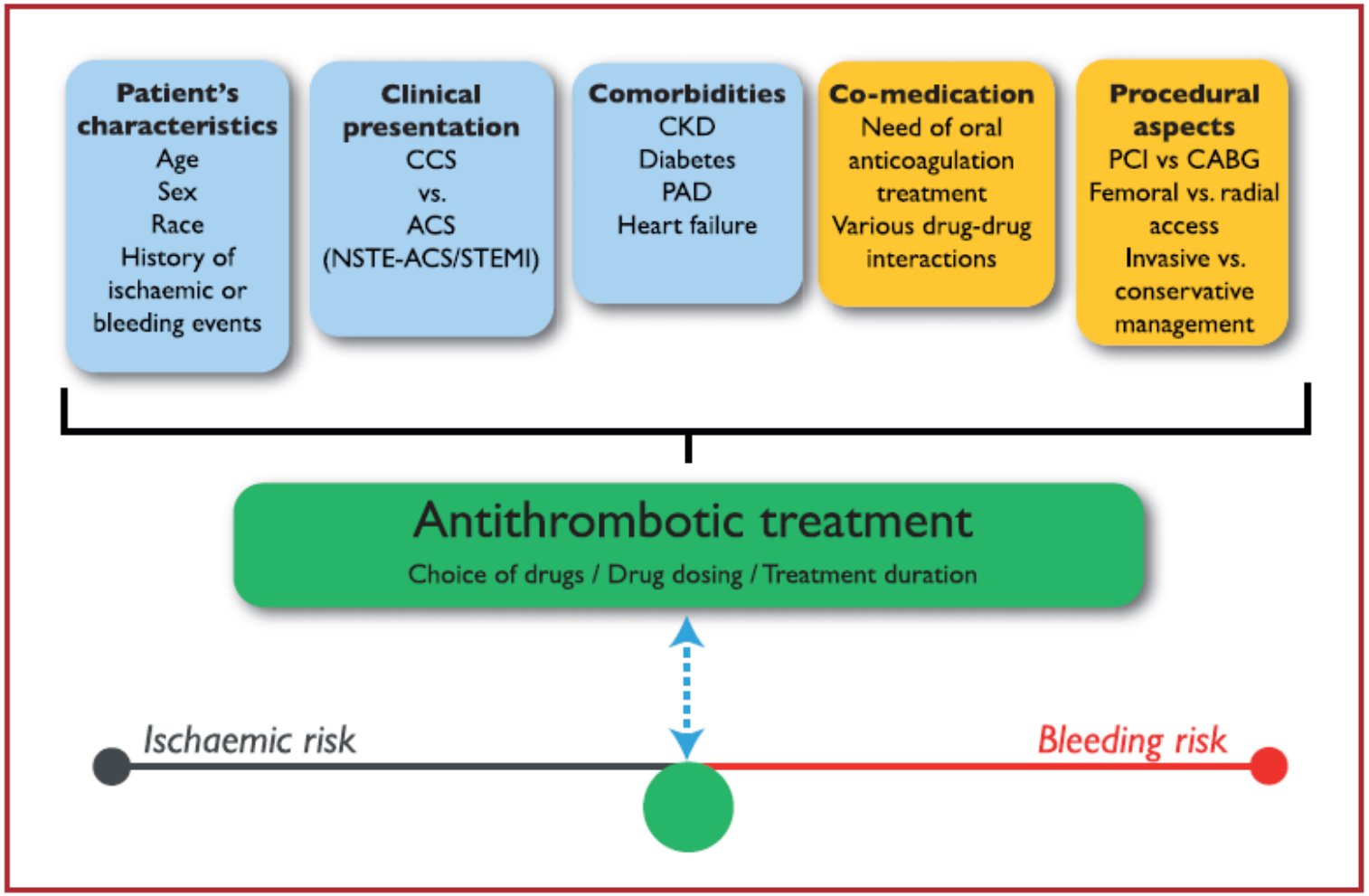
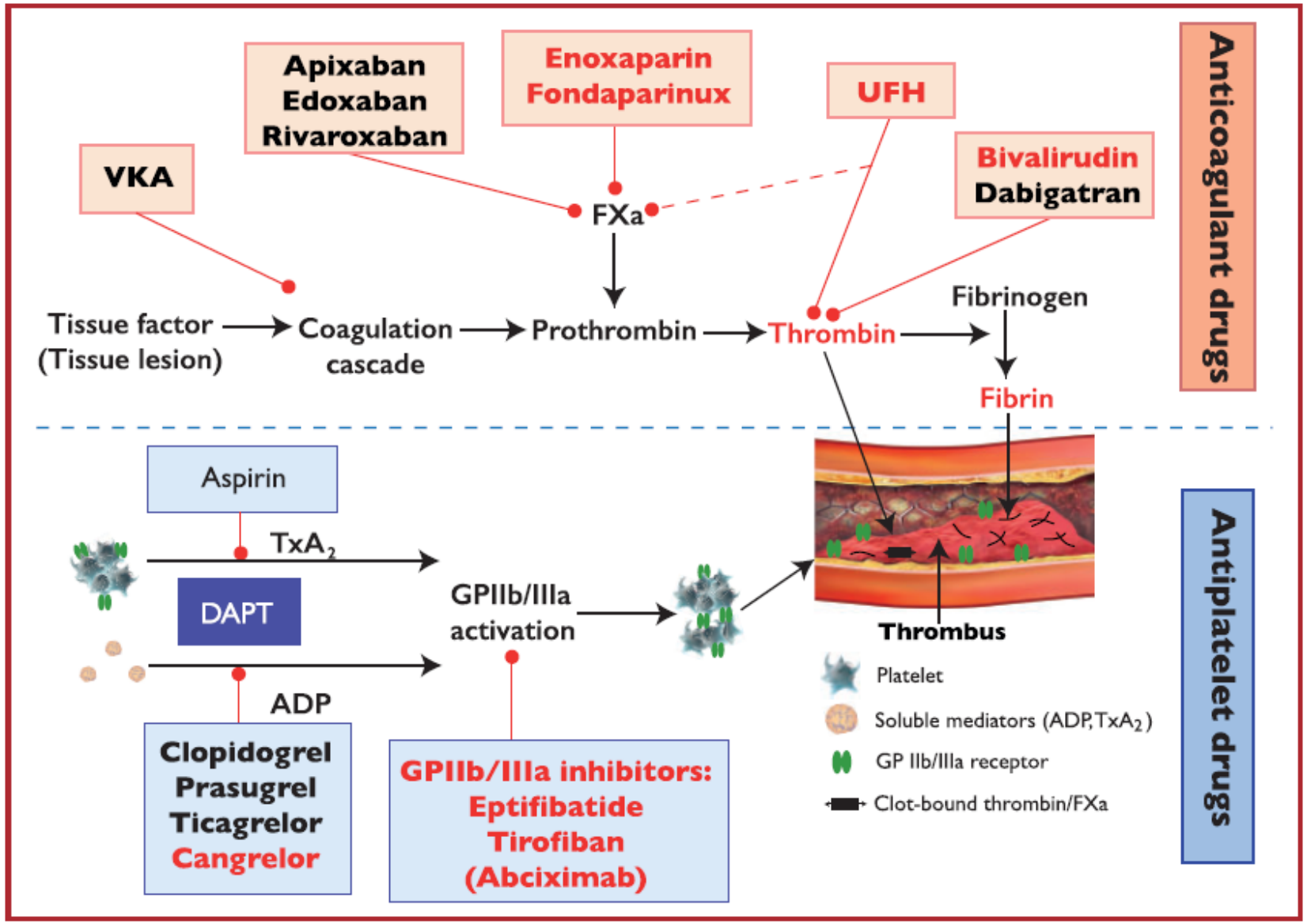
Traitement individualisé



Choisir le bon cocktail



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Antiplaquettaires: choix et durée ?

Aspirin + potent P2Y12 as first choice (prasugrel, ticagrelor) (IB)

DAPT at least 12 months post ACS (IA)

Prasugrel preferred over ticagrelor in NSTE ASC undergoing PCI (IIaB)

Antiplaquettaires: timing de début ?

No preatment with P2Y12 blockers if early invasive strategy (<24h) (IIIA)

Preatment with P2Y12 blockers if no early invasive strategy and low bleeding risk (IIbC)

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DAPT après la sortie

Règle
12 Mo DAPT

DAPT après la sortie

Faire Moins

Stop P2Y12 blockers at 3 Mo if HBR (IIaB)

Stop Aspirin at 3 Mo (IIaB)

De-escalation of P2Y12 blocker (IIbA)

Règle
12 Mo DAPT

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DAPT après la sortie

Faire Moins

Stop P2Y12 blockers at 3 Mo if HBR (IIaB)

Stop Aspirin at 3 Mo (IIaB)

De-escalation of P2Y12 blocker (IIbA)

Règle
12 Mo DAPT

Faire Plus

Aspirin + 2nd Antithrombotic agent
PY12 blockers or Rivaxaban low-dose

High ischemic risk / No HBR (IIaA)

Moderate ischemic risk / No HBR (IIbA)

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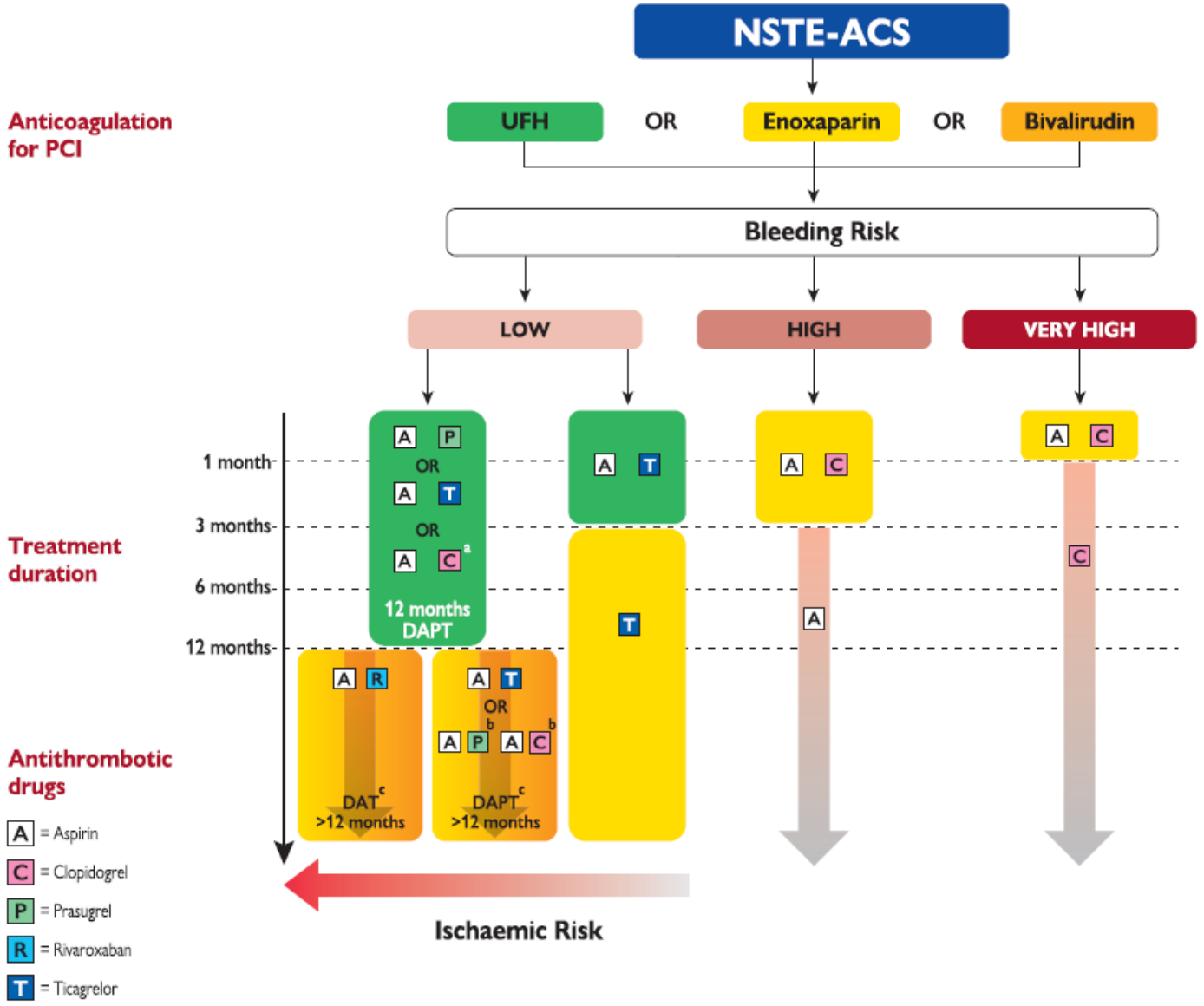
NSTE ASC with PCI and No OAC



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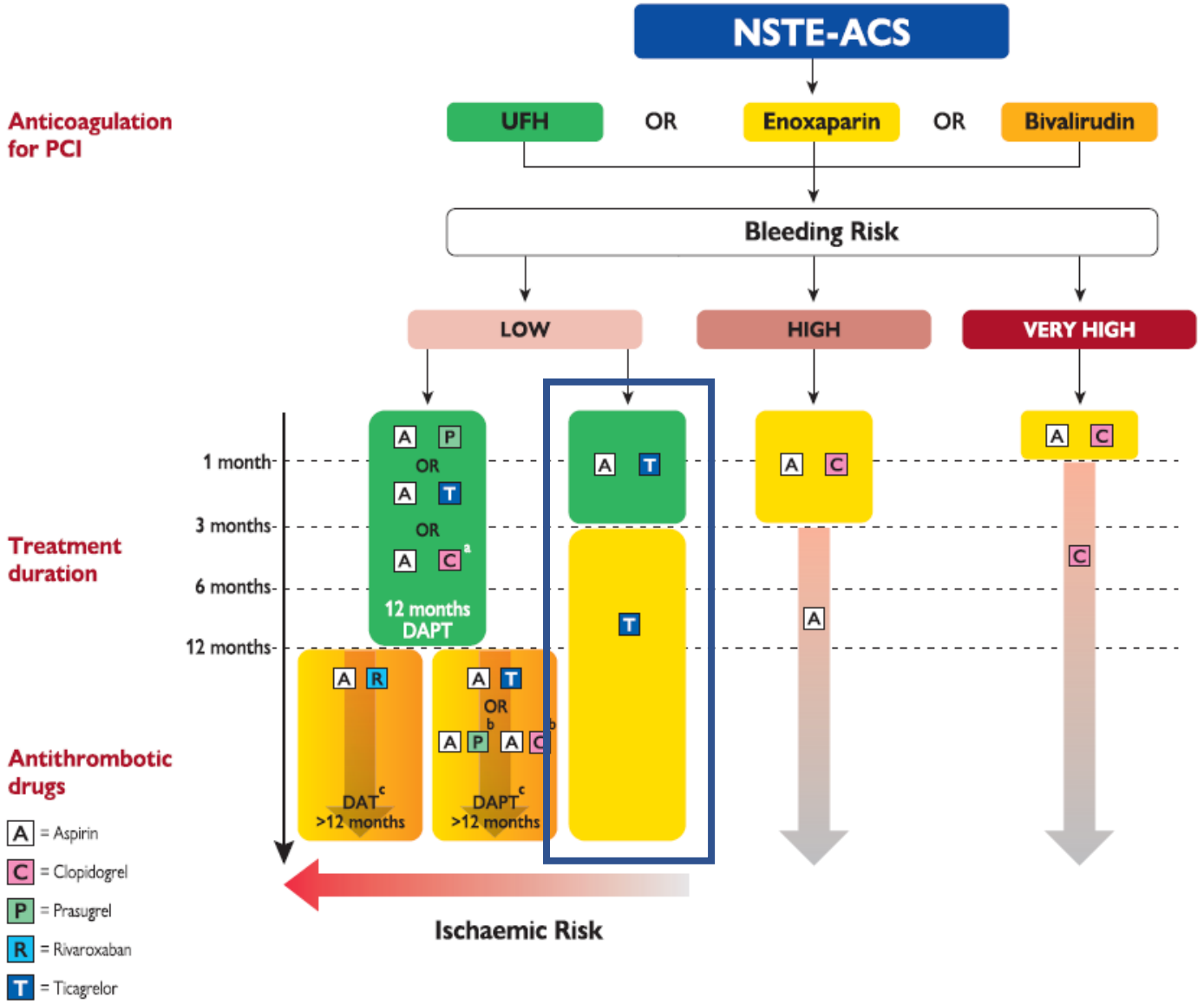
NSTE ASC with PCI and No OAC



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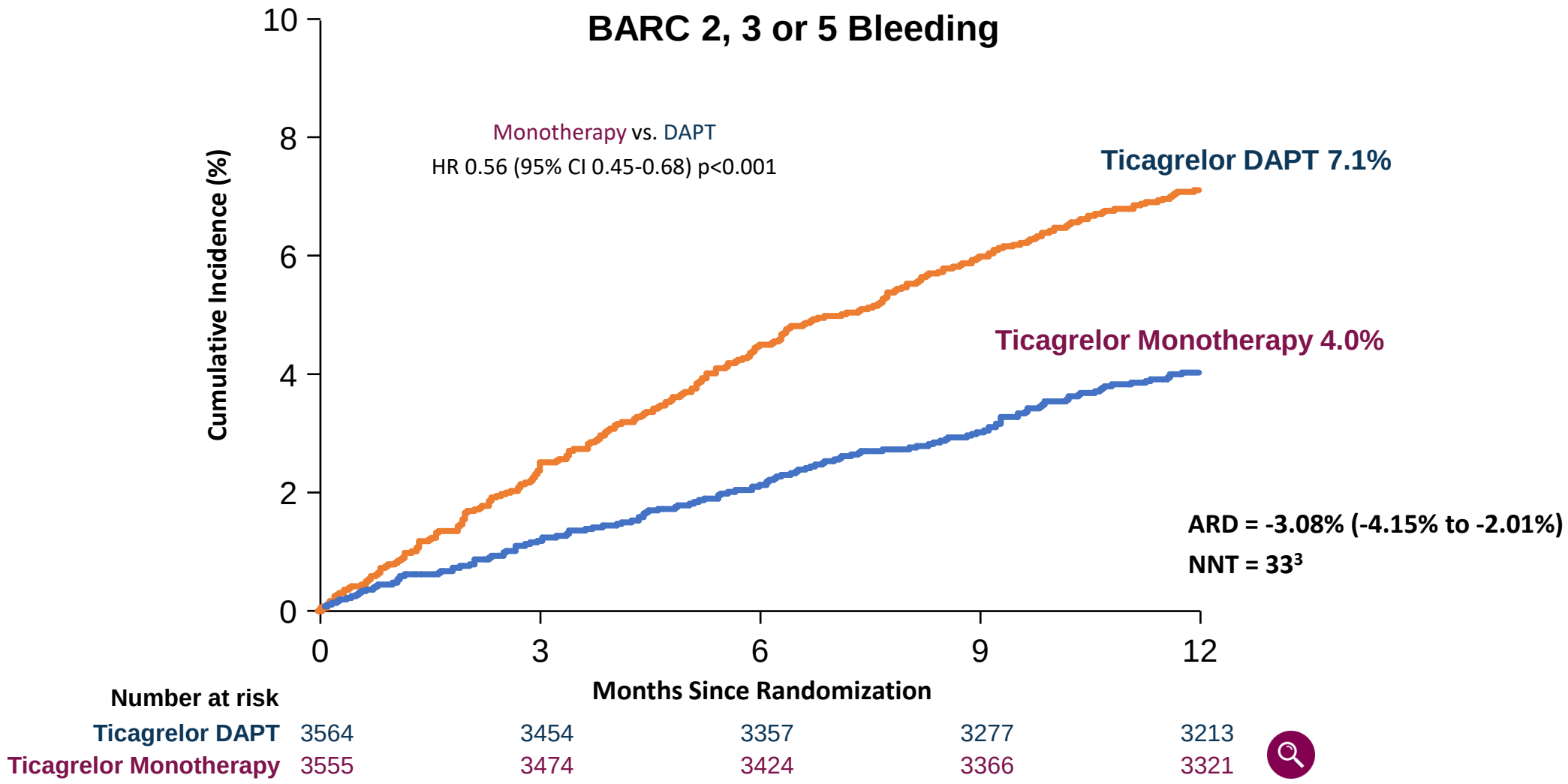
Collet et al, EHJ 2020

TWILIGHT: Primary Endpoint



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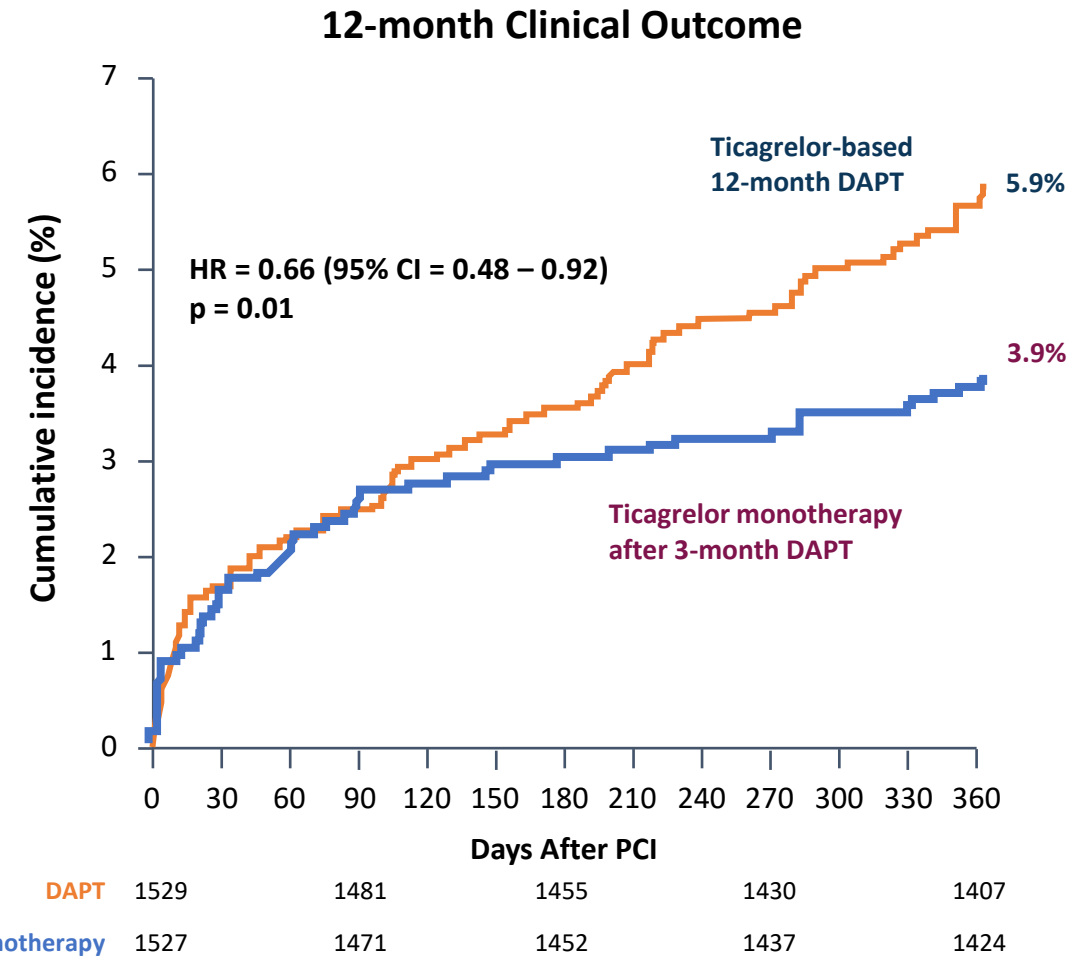
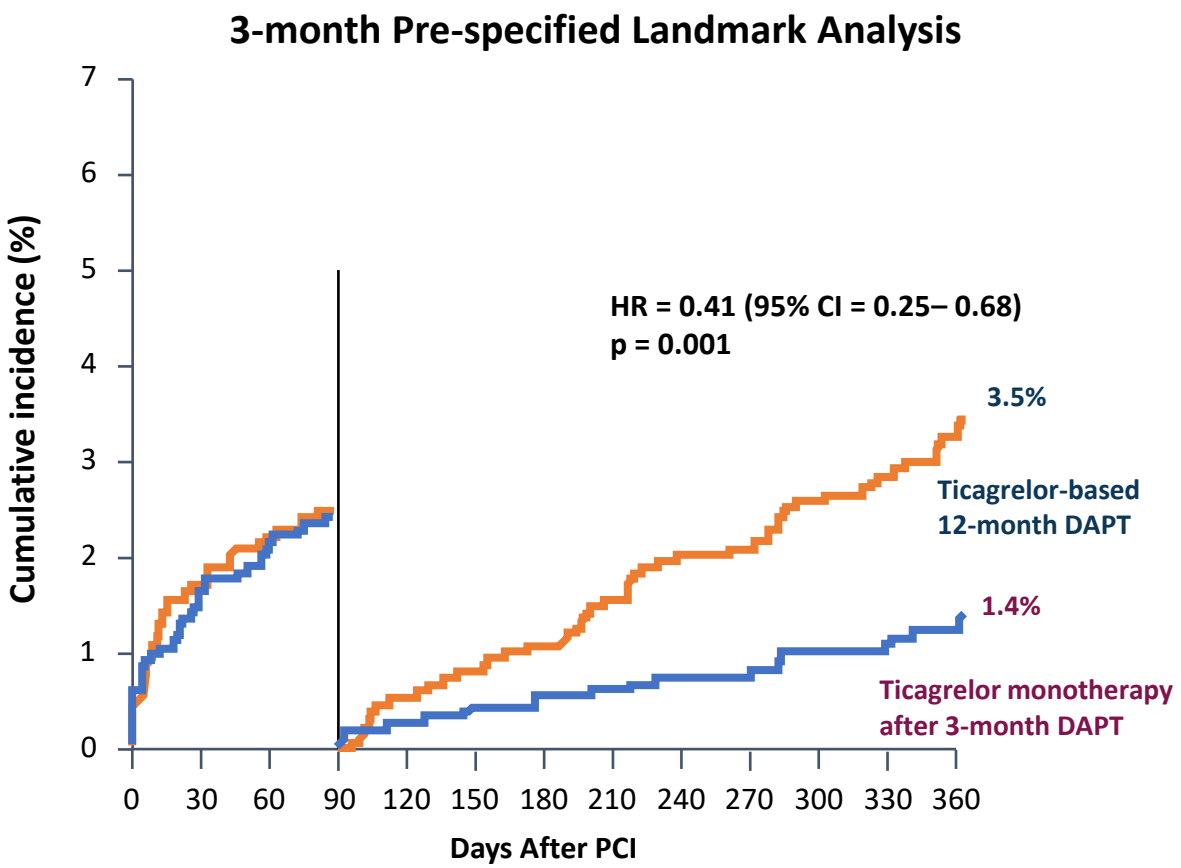
1. Mehran R et al. *N Engl J Med*. 2019; 381:2032-2042

TICO: Primary Endpoint Net Adverse Clinical Events





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Jang Y et al. Presented at: ACC20.WCC; March 28-30, 2020; Virtual.

TWILIGHT and TICO studies

TWILIGHT	TICO
3 Mo DAPT ASA + Tica Followed by Tica 90 BID monotherapy	
Significant reduction of bleeding	
No difference for MACE	
Double-blind, vs Placebo	Open-label
Randomization at M3	Randomization at M0
2/3 ACS, 1/3 CCS	100% ACS
STEMI excluded	1/3 STEMI
Any type of modern DES	100% Orsiro stent
High-risk patients (clinical/angio)	All comers ACS with PCI
Most of HBR included	Most of HBR excluded
Suggesting benefit of TICA monotherapy post ACS after initial DAPT	

What about ticagrelor monotherapy ?

How to select the good patients ?

Role vs others de-escalation strategies ?

De-escalation of DAPT post ACS: strategies ?

De-escalation strategy post ACS = reduction of platelet inhibition < 1 year post ACS
But keeping potent therapy (= compromise)

Stop DAPT and keep ASA or Clopidogrel is not « de-escalaiton »

Optimal Timing: 1 Mo ? 3 Mo ? Tailored for each patient ?

How to do de-escalation ?

Ticagrelor monotherapy *(TWILIGHT, TICO)*

Decrease P2Y12 inhibition
Switch P2Y12 blockers (TOPIC, TROPICAL ACS, POPULAR GENETIC)
Reduce P2Y12 blocker dose (Prasugrel 5 mg in HOST-REDUCE-POLYTECH-ACS)

Different strategies

Supporting same « philosophy »

De-escalation

Interaction Hôpital-Ville dans stratégie AAP

Décision initiale souvent à sortie-post SCA / Médecins hospitaliers

Décision dynamique pendant suivi / médecin de ville ou suivi hospitalier

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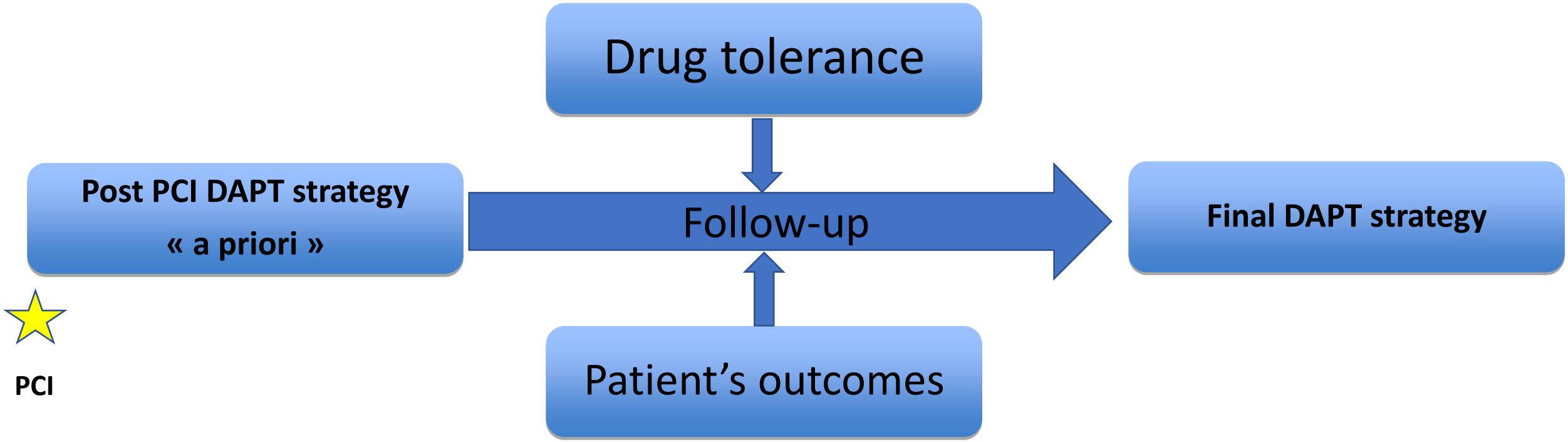
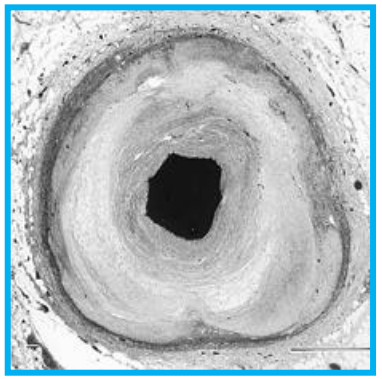
DAPT strategies = dynamic decisions

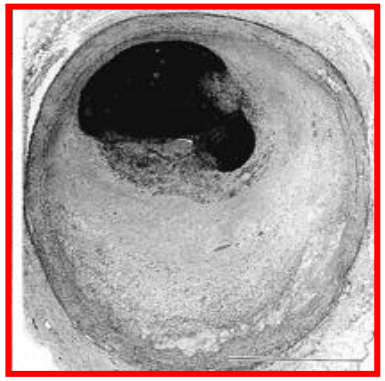


One disease, two presentations

Chronic coronary syndrome

Acute Coronary Syndrome





Stable lesions
Elective PCI

Thrombotic lesions
Urgent PCI

More « PCI related » DAPT decisions

More « ACS related » DAPT decisions

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DAPT duration

DAPT indication

For DES ?
Minimal DAPT

➔ Prevention of stent thrombosis

For the patient ?
Optimal DAPT

➔ Prevention of recurrent events

Short DAPT possible with new DES

But longer DAPT required for selected patients

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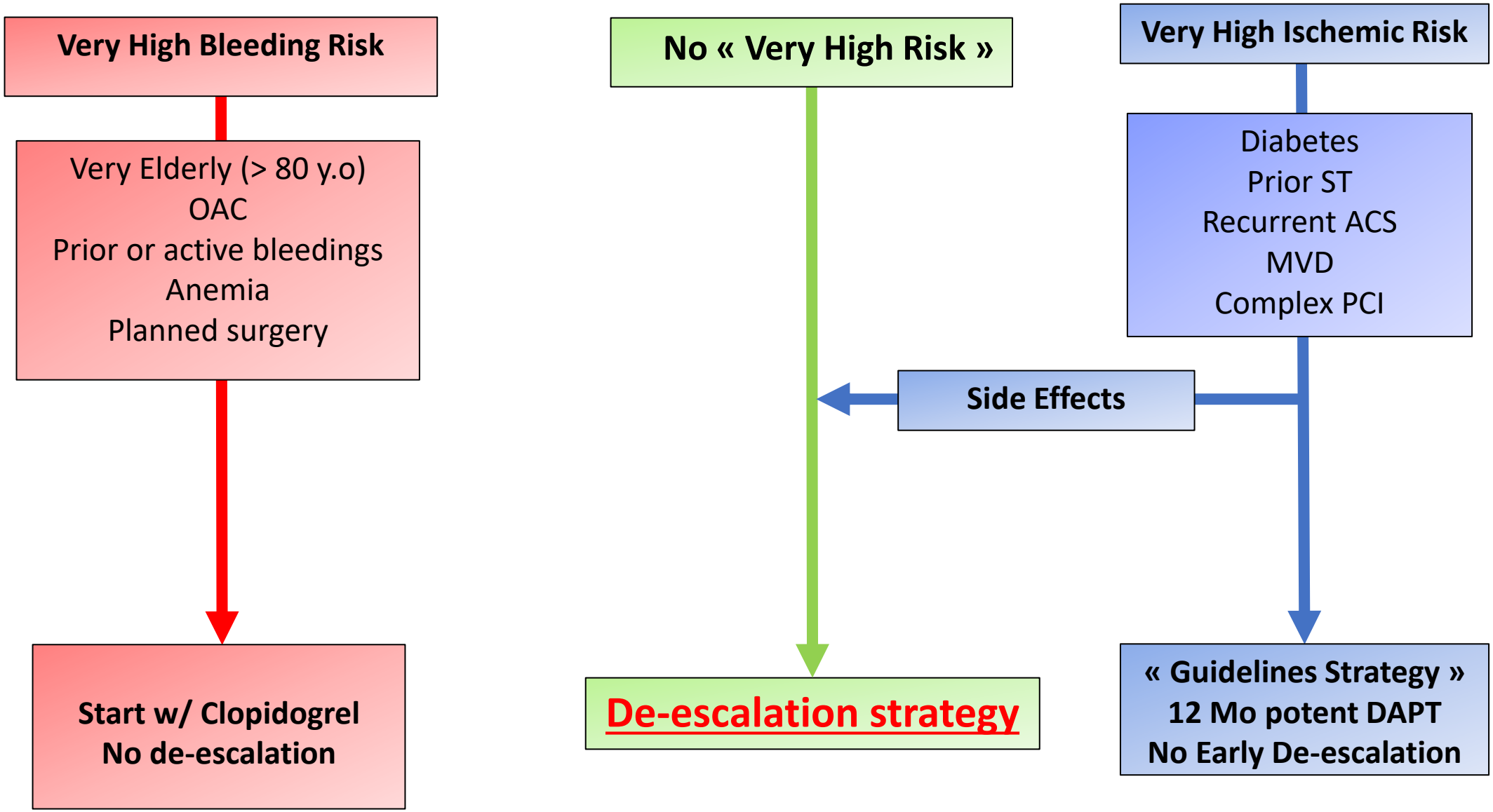
DAPT strategy after ACS



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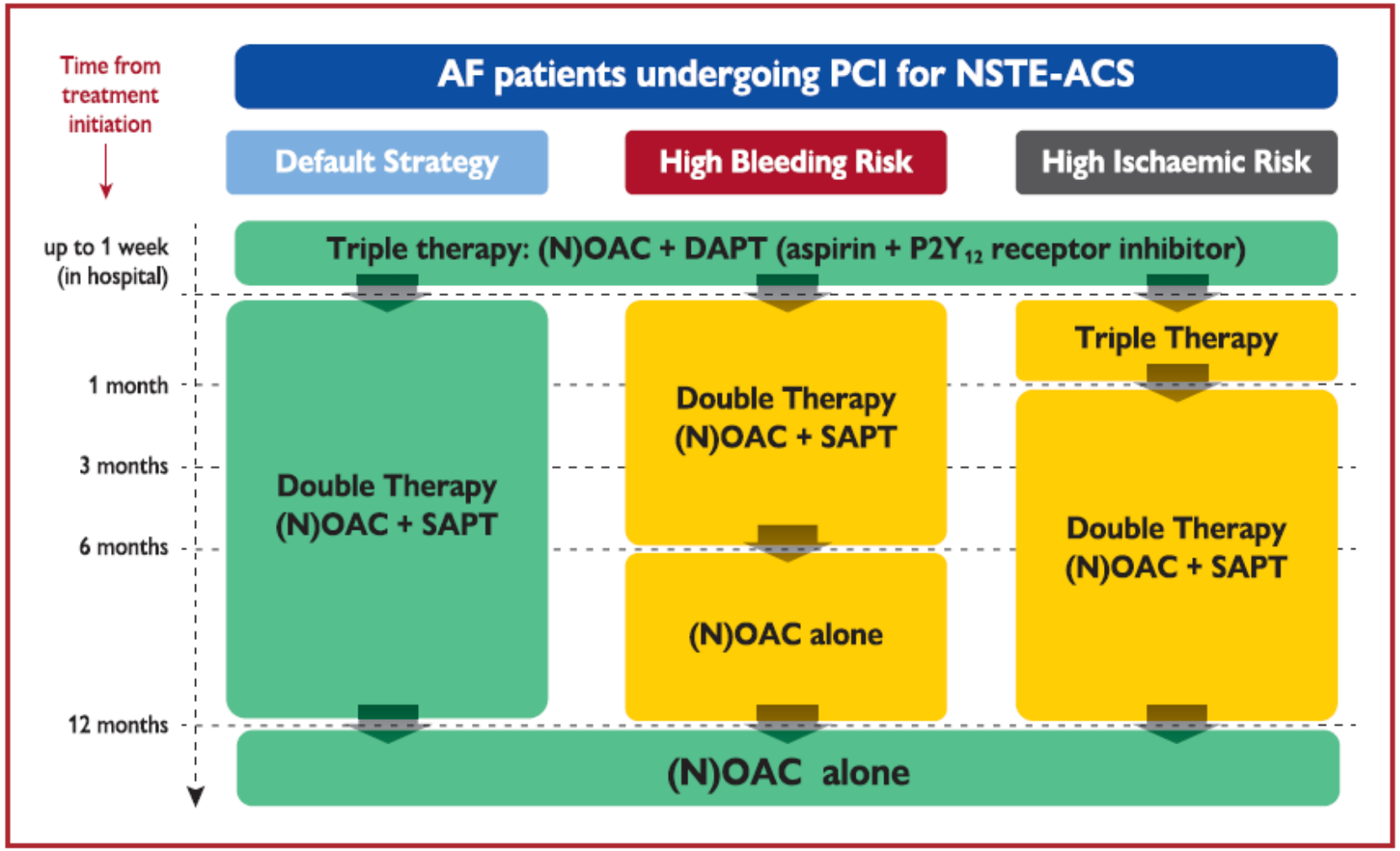
NSTE ASC with PCI and OAC



DAPT after DES for CCS with OAC

When to do « less »?

High Bleeding risk

Shorter Triple therapy (IIa)

Shorter DAT (6 Mo)

Reduced Dose of NOAC (IIa)

Dabigatran, Rivaroxaban

Standard post PCI

Triple therapy 1 week ?

Full dose NOAC (I)

ASA + Clopidogrel (I)

DAT up to 12 Mo
(N)OAC + Clopidogrel

When to do « more » ?

High ischemic risk

Longer triple therapy up to 1 Mo (IIa)

or

DAT with OAC + Tica / Prasu (IIb)

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