Recommandations sur le SCA avec Sus décalage persistant du ST (ACS STEMI)

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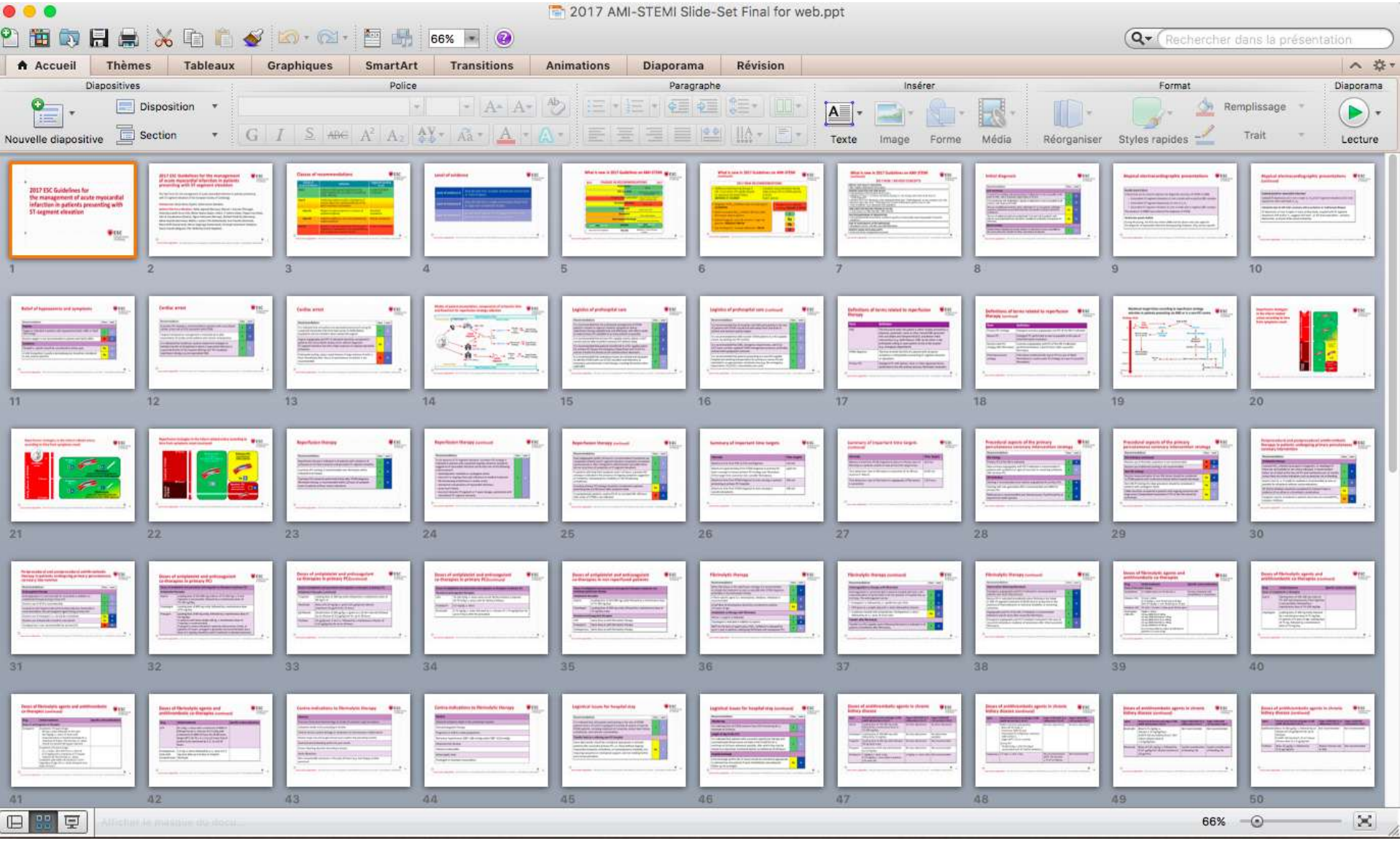
Barcelone, ESC, 26 août 2017

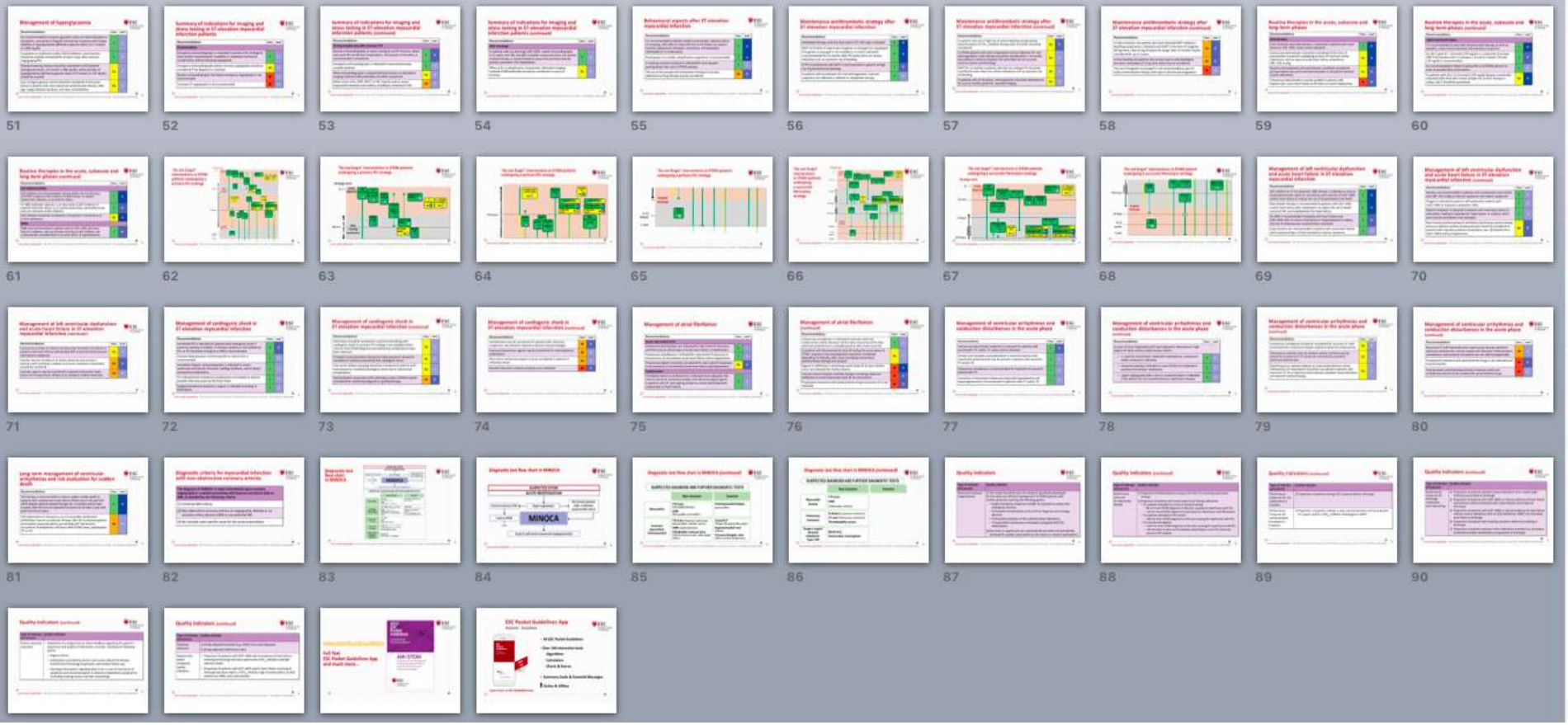
ESC 26-31 Août 2017



EHJ, August, 2017

Diapositives | Police | Paragraphe | Insérer | Format | Diaporama

Nouvelle diapositive | Disposition | Section | Texte | Image | Forme | Média | Réorganiser | Styles rapides | Remplissage | Trait | Lecture



51 52 53 54 55 56 57 58 59 60

61 62 63 64 65 66 67 68 69 70

71 72 73 74 75 76 77 78 79 80

81 82 83 84 85 86 87 88 89 90

Modifications notables dans les recommandations lors de la phase aiguë de l'infarctus du myocarde

- Sur le plan procédural (technique)
  - -L'abord artériel : fémoral ou radial?
  - -Le choix du stent: actif ou passif?
  - -La revascularisation : L'artère responsable vs Tout?
  - -La revascularisation après 48H ?

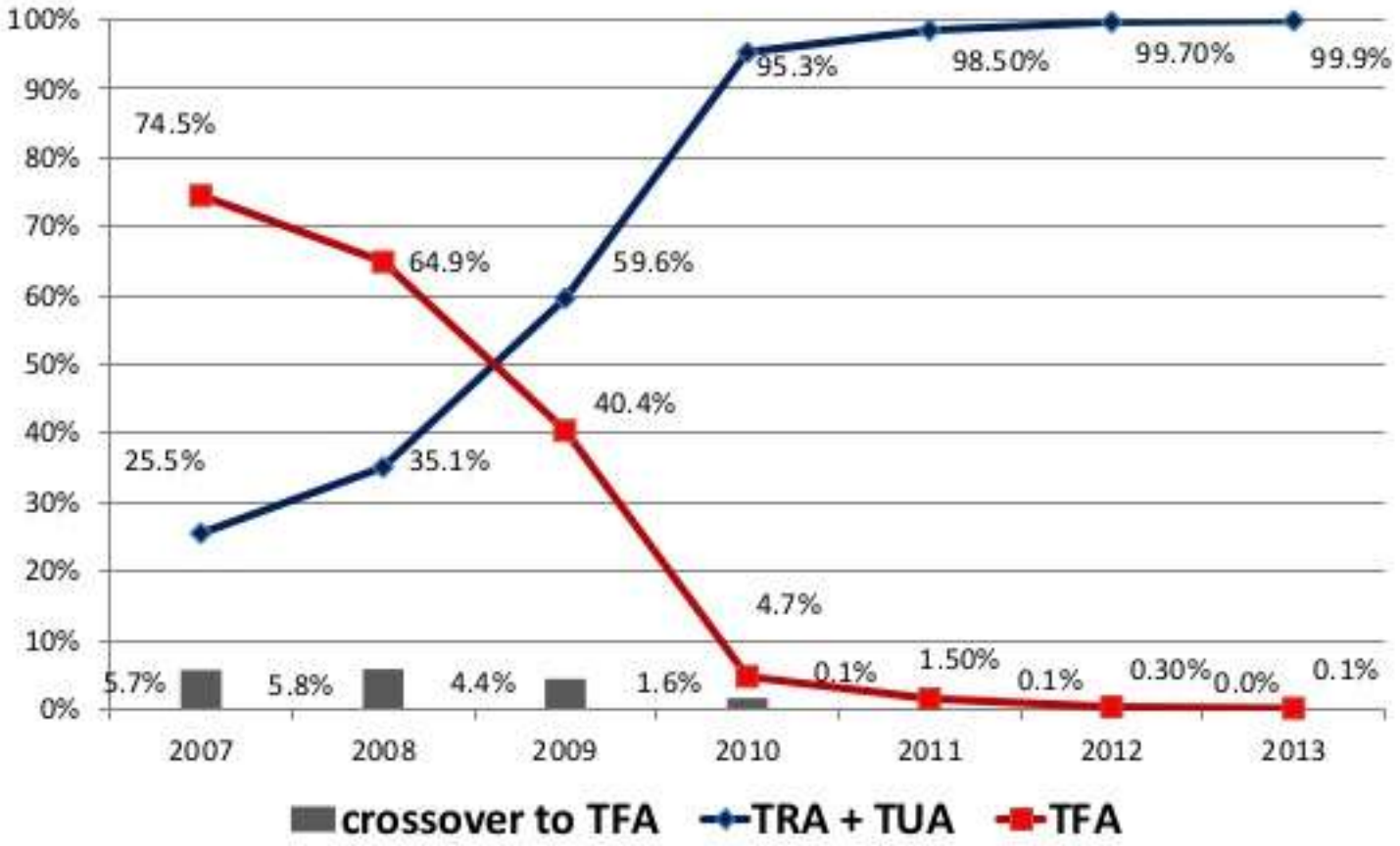
- Sur le plan médicamenteux
  - -Quid de la bivaluridine?
  - -HNF ou HBPM? Et Laquelle?
  - -Oxygénothérapie systématique : oui ou non?
  - -La fibrinolyse (tnk-tpa) : Encore?

(ß-Bloquants, les P2Y12, ….. la PCIA, Th-Aspiration)

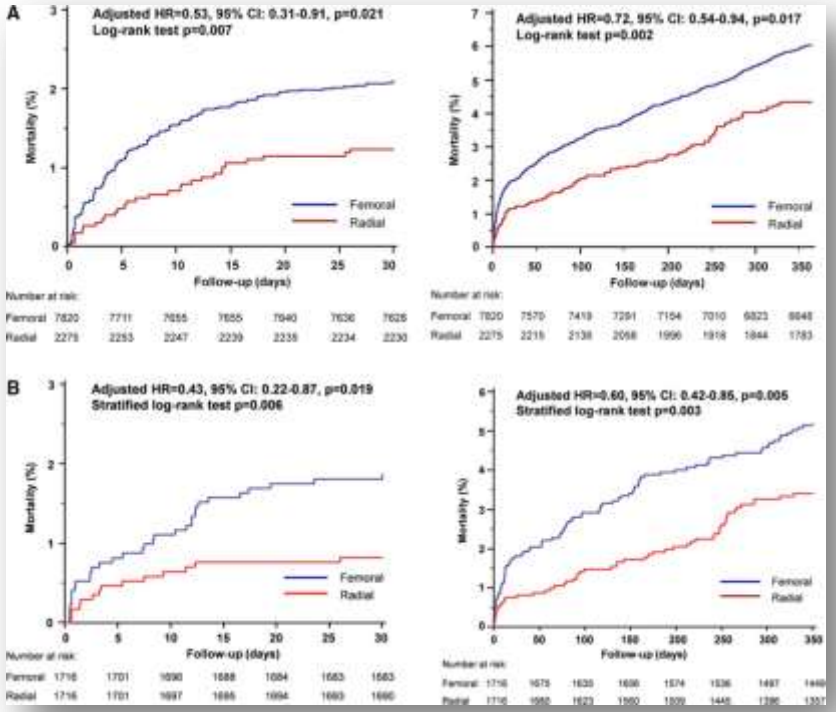
La Radiale ,Voie reine MATRIX

JACC Cardiovasc Interv. 2013 Jun;6(6):548-53. doi: 10.1016/j.jcin.2012.12.129. Epub 2013 May 15.

Completely transferred Access for STEMI PCI



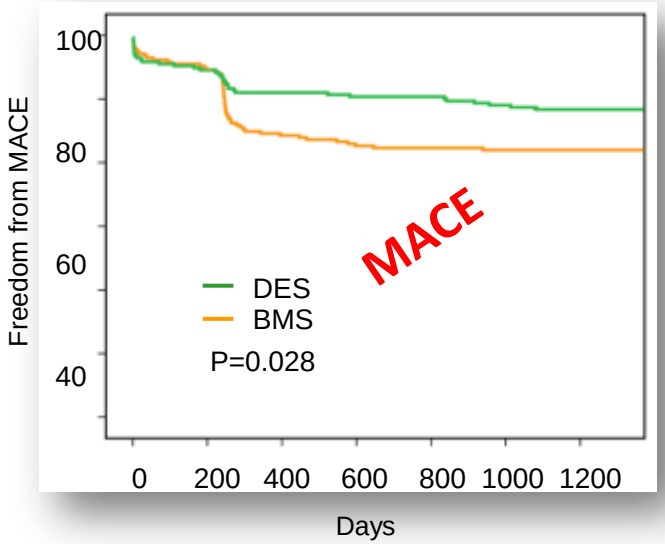
Kalpak O - AIMRADIAL 2014 - Total wrist access for STEMI

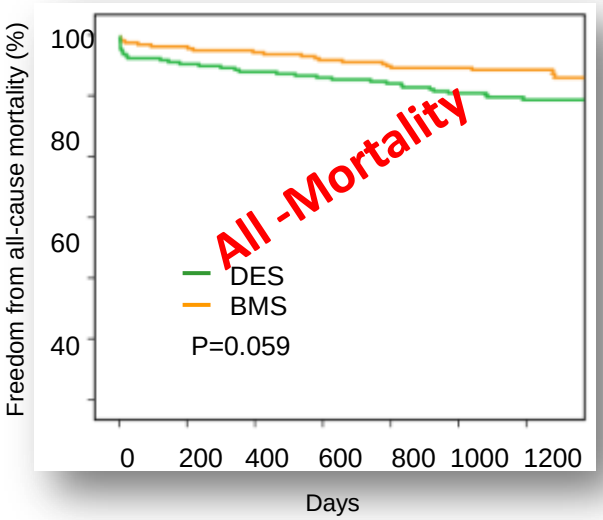


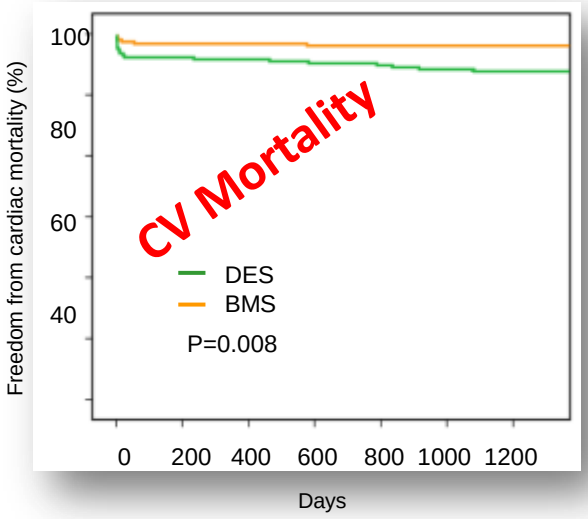
https://doi.org/10.1161/CIRCINTERVENTIONS.114.001314
Circulation: Cardiovascular Interventions. 2014;7:456-464
Originally published June 24, 2014

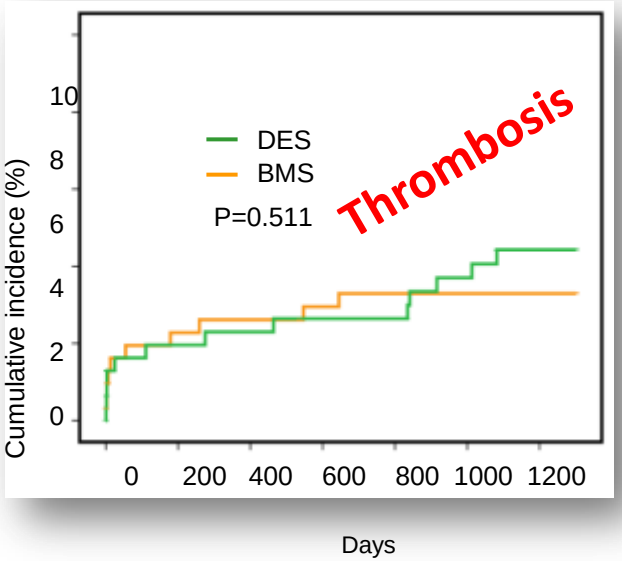
Stent actif prioritaitre : DEDICATION Trial

JACC Cardiovasc Interv. 2013 Jun;6(6):548-53. doi: 10.1016/j.jcin.2012.12.129. Epub 2013 May 15.


Freedom from MACE
100
80
60
40
0
200
400
600
800
1000
1200
Days
DES
BMS
P=0.028
MACE


Freedom from all-cause mortality (%)
100
80
60
40
0
200
400
600
800
1000
1200
Days
DES
BMS
P=0.059
All -Mortality


Freedom from cardiac mortality (%)
100
80
60
40
0
200
400
600
800
1000
1200
Days
DES
BMS
P=0.008
CV Mortality

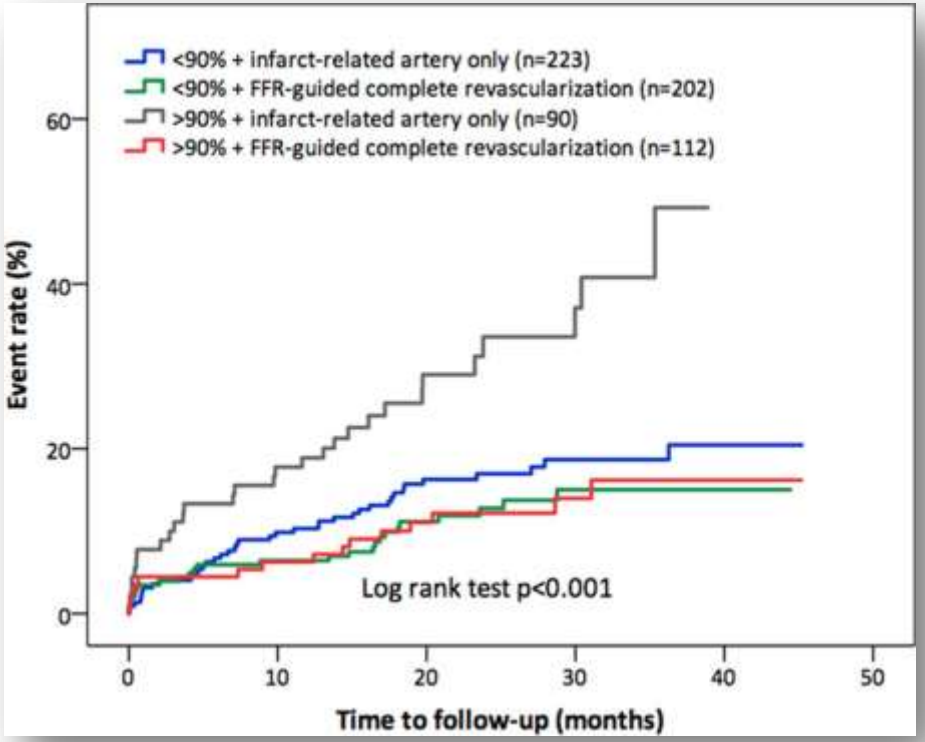

Cumulative incidence (%)
10
8
6
4
2
0
0
200
400
600
800
1000
1200
Days
DES
BMS
P=0.511
Thrombosis

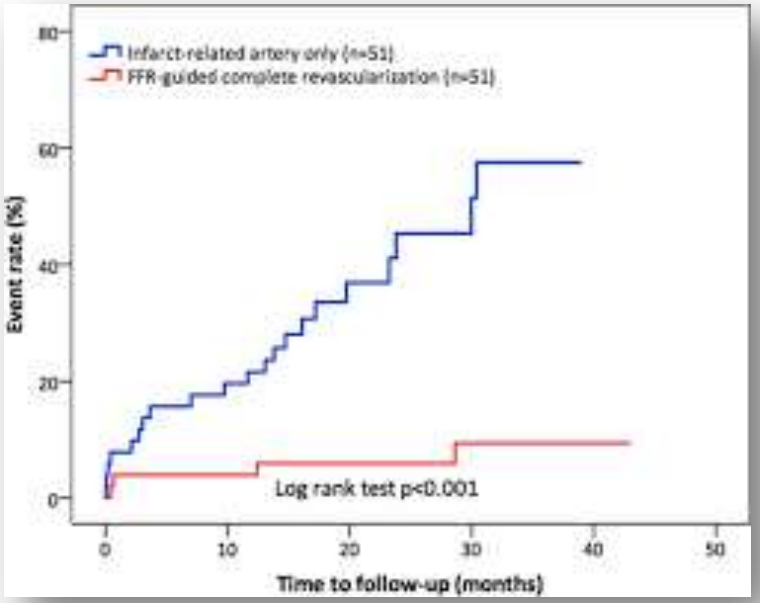
Tout revasculariser?

PRAMI, DANAMI-3-PRIMULTI
CVLPRIT, Compare-Acute

JACC Cardiovasc Interv. 2013 Jun;6(6):548-53. doi: 10.1016/j.jcin.2012.12.129. Epub 2013 May 15.

Tout **revasculariser** oui, mais avec FFR….ou iFR





Revasculariser après 48H?
Le couperet est tombé!

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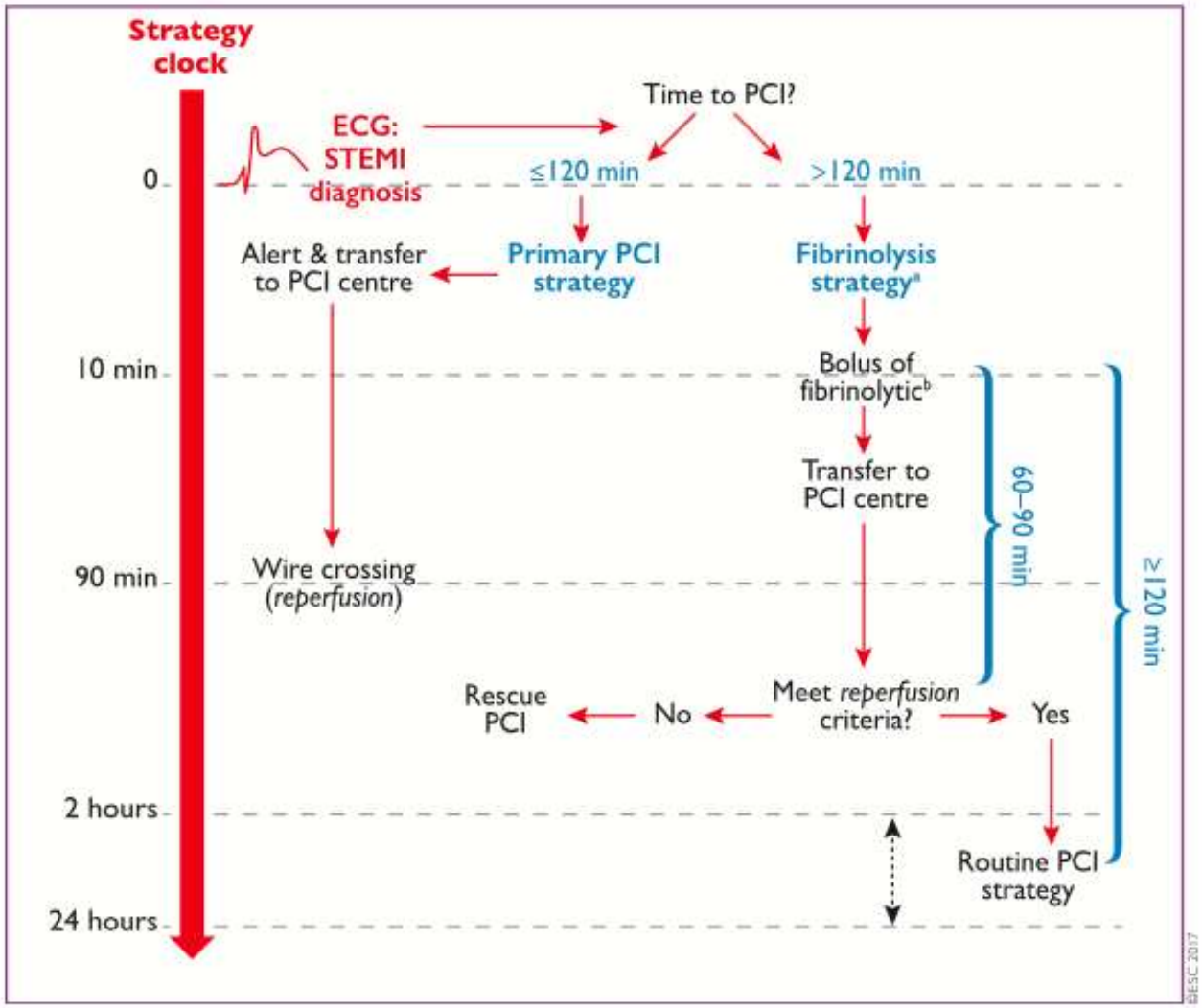
Strategy clock
ECG: STEMI diagnosis
Time to PCI?
≤120 min
>120 min
0
Alert & transfer to PCI centre
Primary PCI strategy
Fibrinolysis strategy[a]
10 min
Bolus of fibrinolytic[b]
Transfer to PCI centre
60–90 min
≥120 min
90 min
Wire crossing (reperfusion)
Rescue PCI
No
Meet reperfusion criteria?
Yes
2 hours
Routine PCI strategy
24 hours
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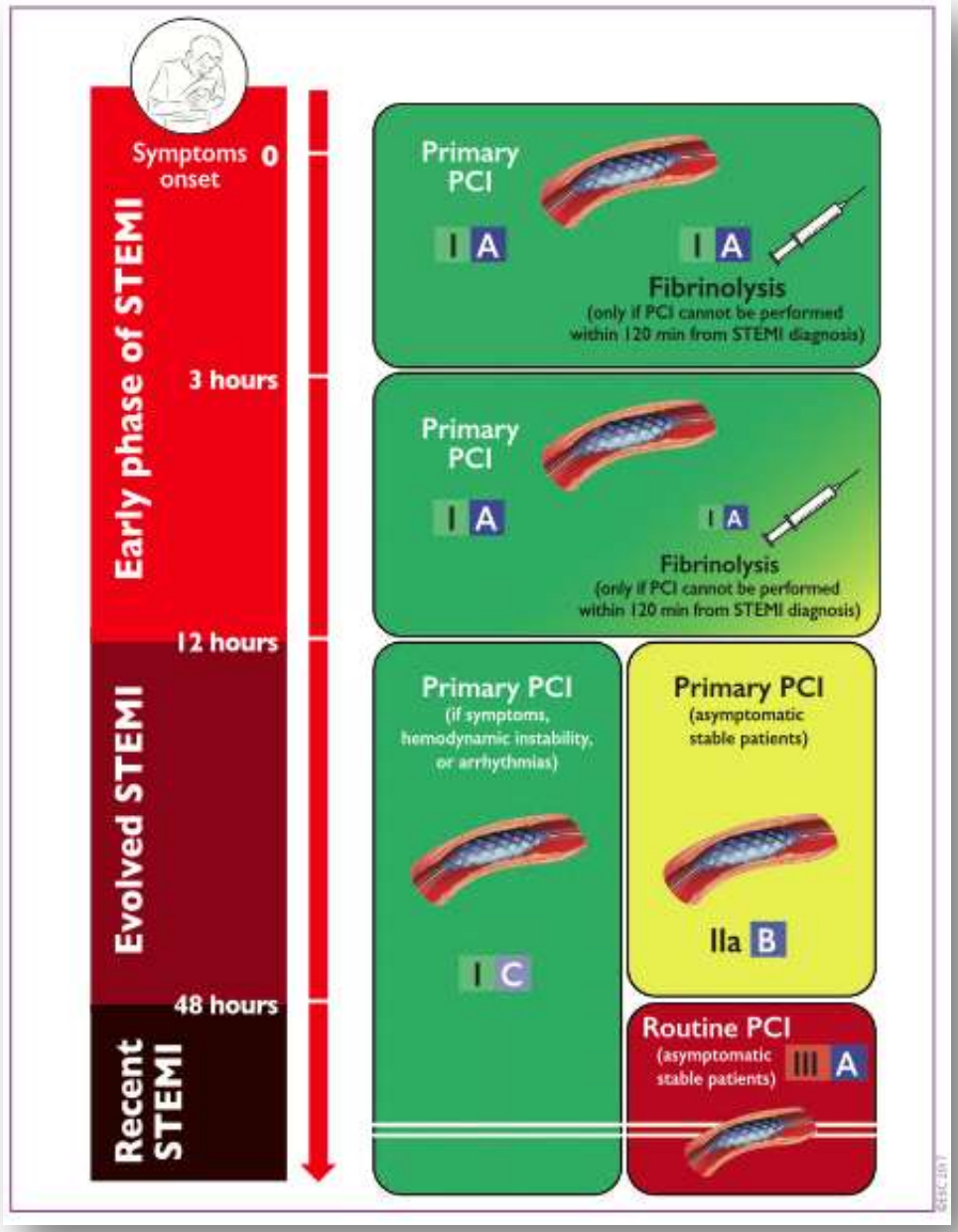
Recommendations for reperfusion therapy

Recommendation	Class[a]	Level[b]
Reperfusion therapy is indicated in all patients with symptoms of ischaemia of ≤12 h duration and persistent ST-segment elevation.	I	A
A primary PCI strategy is recommended over fibrinolysis within indicated timeframes.	I	A
If timely primary PCI cannot be performed after STEMI diagnosis, fibrinolytic therapy is recommended within 12 h of symptom onset in patients without contraindications.	I	A
In the absence of ST-segment elevation, a primary PCI strategy is indicated in patients with suspected ongoing ischaemic symptoms suggestive of MI and at least one of the following criteria present: - 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-segment or T-wave changes, particularly with intermittent ST-segment elevation.	I	C
Early angiography (within 24 h) is recommended if symptoms are completely relieved and ST-segment elevation is completely normalized spontaneously or after nitroglycerin administration (provided there is no recurrence of symptoms or ST-segment elevation).	I	C
In patients with time from symptom onset >12 h, a primary PCI strategy is indicated in the presence of ongoing symptoms suggestive of ischaemia, haemodynamic instability,	I	C
A routine primary PCI strategy should be considered in patients presenting late (12–48 h) after symptom onset.	IIa	B
In asymptomatic patients, routine PCI of an occluded IRA >48 h after onset of STEMI is not indicated.	III	A

IRA = infarct-related artery; MI, myocardial infarction; PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.
[a]Class of recommendation.
[b]Level of evidence.

A routine primary PCI strategy should be considered in patients presenting late (12–48 h) after symptom onset.[133,134,142]	IIa	B
In asymptomatic patients, routine PCI of an occluded IRA >48 h after onset of STEMI is not indicated.[135,137]	III	A

IRA = infarct-related artery; MI, myocardial infarction; PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.
[a]Class of recommendation.
[b]Level of evidence.


Symptoms onset
0
Early phase of STEMI
3 hours
Evolved STEMI
12 hours
Recent STEMI
48 hours
Primary PCI
I A
I A
Fibrinolysis
(only if PCI cannot be performed within 120 min from STEMI diagnosis)
Primary PCI
I A
I A
Fibrinolysis
(only if PCI cannot be performed within 120 min from STEMI diagnosis)
Primary PCI
(if symptoms, hemodynamic instability, or arrhythmias)
I C
Primary PCI
(asymptomatic stable patients)
IIa B
Routine PCI
(asymptomatic stable patients)
III A

Bivaluridine:
MATRIX, HEAT-PPCI

IA à IIB

Thromboaspiration de routine : TOTAL et TASTE

IIB à III

ESC Guidelines

ratio 1.56, 95% CI 1.02–2.42, P =0.04]. However, the interaction P values were 0.32 and 0.34, respectively.[162]

In the Taste[157] and TOTAL trials[159], 1–5% of randomized patients crossed over from PCI alone to thrombus aspiration. Based on these data and the results of a recent meta-analysis,[162] routine thrombus aspiration is not recommended, but in cases of large residual thrombus burden after opening the vessel with a guide wire or a balloon, thrombus aspiration may be considered.

III

IIB

?

Héparines:

HNF : oui encore et encore…

Enoxaparine IIB à IIA

Pas les autres HBPM

Oxygénothérapie systématique: AVOID, DETO2X

Oxygen is indicated in hypoxic patients with arterial oxygen saturation (SaO_2) < 90%. There is some evidence suggesting that hyperoxia may be harmful in patients with uncomplicated MI, presumably due to increased myocardial injury.[64–67] Thus, routine oxygen is not recommended when SaO_2 is ≥ 90%.

Relief of hypoxaemia and symptoms

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Recommendations	Class	Level
Hypoxia		
Oxygen is indicated in patients with hypoxaemia (SaO2 <90% or PaO2 <60 mmHg).	I	C
Routine oxygen is not recommended in patients with SaO2 ≥90%.	III	B
Symptoms		
Titrated i.v. opioids should be considered to relieve pain.	IIa	C
A mild tranquillizer (usually a benzodiazepine) should be considered in very anxious patients.	IIa	C

Que retenir?

Modifications notables dans les recommandations lors de la phase aiguë de l'infarctus du myocarde

- Sur le plan procédural (technique)
  - -L'abord artériel : **Radial IIA vers IA**
  - -Le choix du stent: **Actif IIA vers IA**
  - -La revascularisation : **Tout IIIA vers IIA**
  - -La revascularisation après 48H : **IIIA**

- Sur le plan médicamenteux
  - -Quid de la bivaluridine? **De IB vers IIA**
  - -HNF ou HBPM? Et laquelle? **Enoxaparine IIA**
  - -Oxygénothérapie systématique : **oui si SaO2<90% IA**
  - -La fibrinolyse (tnk-tpa) : **½ dose pour >75 ans**

(ß-Bloquants, les P2Y12, …..la PCIA, Th-Aspiration)

What is new in 2017 Guidelines on AMI-STEMI

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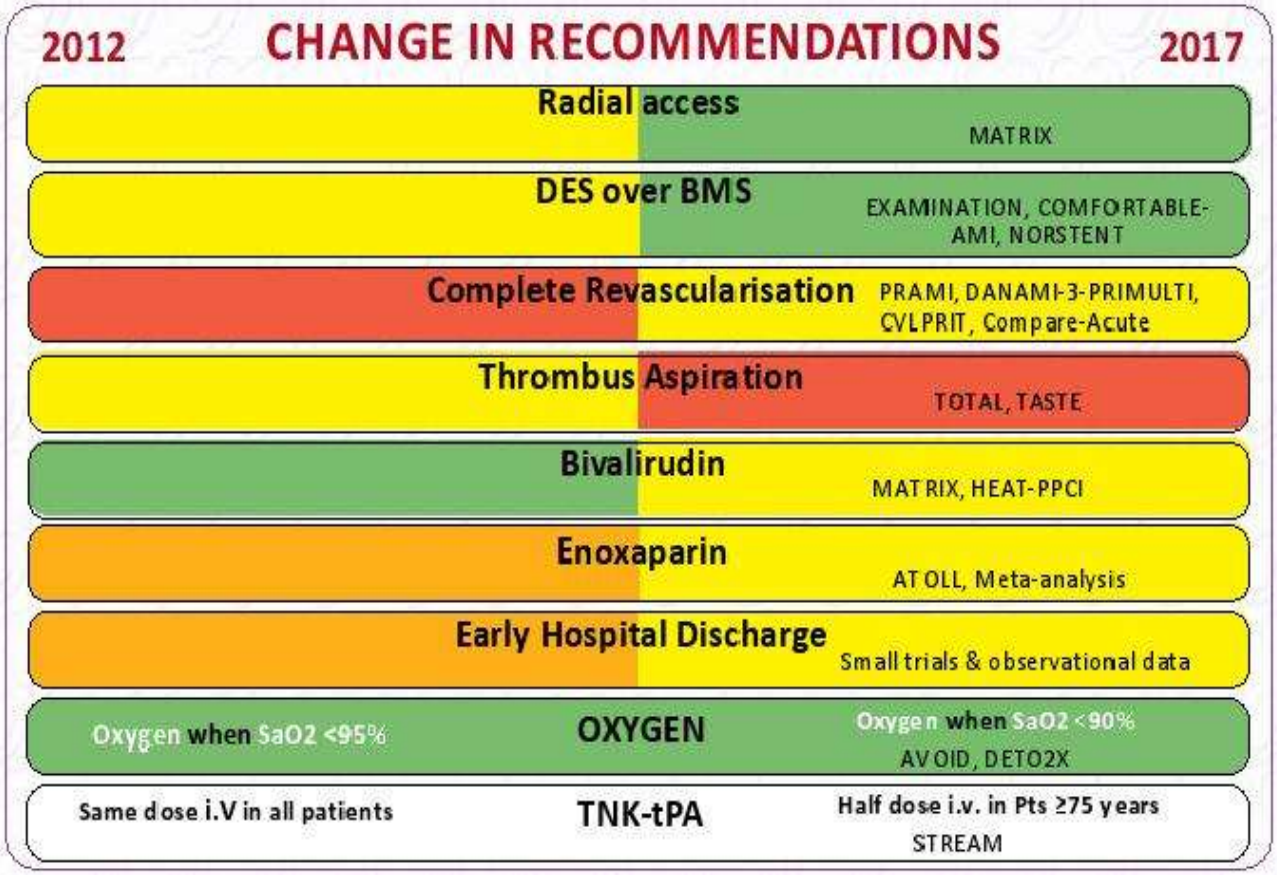

www.escardio.org/guidelines 2017 ESC Guidelines for the Management of AMI-STEMI (European Heart Journal 2017 - doi:10.1093/eurheartj/ehx095)

Merci