ESC European Society of Cardiology

European Heart Journal (2017) 00, 1–60
doi:10.1093/eurheartj/ehx095

ESC GUIDELINES

Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended / is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	Weight of evidence/opinion in favour of usefulness/efficacy.	Should be considered
Class IIb	Usefulness/efficacy is less well established by evidence/opinion.	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

2017 ESC Guidelines on the Diagnosis and Treatment of Peripheral Arterial Diseases, in collaboration with the European Society for Vascular Surgery (ESVS)

Document covering atherosclerotic disease of extracranial carotid and vertebral, mesenteric, renal, upper and lower extremity arteries

Endorsed by: the European Stroke Organization (ESO)

The Task Force for the Diagnosis and Treatment of Peripheral Arterial Diseases of the European Society of Cardiology (ESC) and of the European Society for Vascular Surgery (ESVS)

I IIa IIb III

Authors/Task Force Members:

Victor Aboyans* (ESC Chairperson) (France),

Jean-Baptiste Ricco*1 (Co-Chairperson) (France),

DÉCLARATION DE LIENS D'INTÉRÊT AVEC LA PRÉSENTATION

Intervenant : JEAN MARC PERNES HOPITAL PRIVE ANTONY

☑ Je n'ai pas de lien d'intérêt à déclarer

MAIS INTERET A EVITER LES CONFLITS , AU CONTRAIRE!!!!!

General recommendations on the management of patients with peripheral arterial diseases

Recommendations	Class[a]	Level[b]
In healthcare centres, it is recommended to set up a multidisciplinary Vascular Team to make decisions for the management of patients with PADs.	I	C
It is recommended to implement and support initiatives to improve medical and public awareness of PADs, especially cerebrovascular and lower extremity artery diseases.	I	C

Changements /2011 et nouvelles reco 2017 sur la maladie athéromateuse artérielle périphérique

(donc hors Coronaire et Aorte)

- **Troncs Supra Aortiques** (Carotide extra cranienne, vertébrale, sous-clavière)
- **Artères viscérales de l'aorte abdominale**(digestives, rénales)
- **Artères des Membres Inférieurs**
- **Traitement antithrombotique** (Anticoagulants et Antiagrégants)
- **Le polyvasculaire**(atteinte coronaire et périphérique)
- **Pathologie cardiaque associée** (Insufisance cardiaque, AC/FA)

CAROTIDE EXTRA CRANIENNE

Ré-évaluation de la revascularisation d'une sténose carotide(50% NASCET)à l'aune du BMT(Best Medical Therapy):

Métaanalyse 41 études taux d'AVC annuel: 2.3/100 patients <2000 VS 1.0/1OO >2000 soit **70% REDUCTION /AN**

Bénéfice modeste mais réel de la revasc CHIR chez l'asymptomatique(ARR :4.6% à 10 ans),95% d'intervention inutile....

Nécessité d'individualiser le sous-groupe de sujets à haut risque d'AVC

Recommendations in patients with peripheral arterial diseases: best medical therapy

Recommendations	Class[a]	Level[b]
Smoking cessation is recommended in all patients with PADs.[27,28]	I	B
Healthy diet and physical activity are recommended for all patients with PADs.	I	C
Statins are recommended in all patients with PADs.[31,32]	I	A
In patients with PADs, it is recommended to reduce LDL-C to < 1.8 mmol/L (70 mg/dL) or decrease it by ≥ 50% if baseline values are 1.8–3.5 mmol/L (70–135 mg/dL).[25]	I	C
In diabetic patients with PADs, strict glycaemic control is recommended.	I	C
Antiplatelet therapy is recommended in patients with symptomatic PADs.[51]	I	C[d]
In patients with PADs and hypertension, it is recommended to control blood pressure at < 140/90 mmHg.[41,42,52]	I	A
ACEIs or ARBs should be considered as first-line therapy[c] in patients with PADs and hypertension.[47,53]	IIa	B

Recommendations for management of asymptomatic carotid artery disease

Recommendations	Class[a]	Level[b]
In 'average surgical risk' patients with an asymptomatic 60–99% stenosis, CEA should be considered in the presence of clinical and/or more imaging characteristics[c] that may be associated with an increased risk of late ipsilateral stroke, provided documented perioperative stroke/death rates are <3% and the patient's life expectancy is > 5 years.[116]	IIa	B
In asymptomatic patients who have been deemed 'high risk for CEA'[d] and who have an asymptomatic 60–99% stenosis in the presence of clinical and/or imaging characteristics[c] that may be associated with an increased risk of late ipsilateral stroke, CAS should be considered, provided documented perioperative stroke/death rates are <3% and the patient's life expectancy is > 5 years.[135,136]	IIa	B
In 'average surgical risk' patients with an asymptomatic 60–99% stenosis in the presence of clinical and/or imaging characteristics[d] that may be associated with an increased risk of late ipsilateral stroke, CAS may be an alternative to CEA provided documented perioperative stroke/death rates are <3% and the patient's life expectancy is > 5 years.[110,129,132,137]	IIb	B

FACTEURS DE RISQUE D'AVC HOMOLATERAL

unication Education

Clinical*	• Contralateral TIA/stroke[121]
Cerebral imaging	• Ipsilateral silent infarction[122]
Ultrasound imaging	• Stenosis progression (> 20%)[123] • Spontaneous embolization on transcranial Doppler (HITS)[124] • Impaired cerebral vascular reserve[125] • Large plaques[b126] • Echolucent plaques[96] • Increased juxta-luminal black (hypoechogenic) area[127]
MRA	• Intraplaque haemorrhage[128] • Lipid-rich necrotic core

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- Age >80 years
- Clinically significant cardiac disease
- Severe pulmonary disease
- Contralateral internal carotid artery occlusion
- Recurrent laryngeal nerve palsy
- Previous radical neck surgery or radiotherapy
- Recurrent stenosis after CEA.

ASYMTOMATIQUE A RISQUE D'AVC ET FAIBLE RISQUE CHIR : ENDARTERIECTOMIE (II a B)

ASYMPTOMATIQUE A RISQUE D'AVC ET HAUT RISQUE CHIR: ENDOV (II a B)

ASYMPTOMATIQUE A RISQUE D'AVC ET ET FAIBLE RISQUE CHIR : ENDOVASC PEUT ETRE CONSIDERE(II b B)

Recommendations on revascularization in patients with symptomatic carotid disease*

Recommendations	Class[a]	Level[b]
CEA is recommended in symptomatic patients with 70–99% carotid stenoses, provided the documented procedural death/stroke rate is < 6%.[138,147]	I	A
CEA should be considered in symptomatic patients with 50–69% carotid stenoses, provided the documented procedural death/stroke rate is < 6%.[138,147]	IIa	A
In recently symptomatic patients with 50–99% stenosis who present with adverse anatomical features or medical comorbidities that are considered to make them 'high risk for CEA', CAS should be considered, provided the documented procedural death/stroke rate is < 6%.[135,145,152]	IIa	B
When revascularization is indicated in 'average surgical risk' patients with symptomatic carotid disease, CAS may be considered as an alternative to surgery, provided the documented procedural death/stroke rate is < 6%.[152,153]	IIb	B
When decided, it is recommended to perform revascularization of symptomatic 50–99% carotid stenoses as soon as possible, preferably within 14 days of symptom onset.[138,154,155]	I	A
Revascularization is not recommended in patients with a < 50% carotid stenosis.[138]	III	A

*Stroke or TIA occurring within 6 months.

Recommendation on the use of embolic protection device during carotid stenting

Recommendation	Class[a]	Level[b]
The use of embolic protection devices should be considered in patients undergoing carotid artery stenting.	IIa	C

SYMPTOMATIQUE
AVEC STENOSE > 70 %: CHIR (I A)
AVEC STENOSE >50% et < 70% : CHIR (II a A)
SYMPTOMATIQUE A HAUT RISQUE CHIR:
ENDOVASC(II a B)

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- ARTERES VERTEBRALE ET SOUSCLAVIERE

CHIR OU ENDOV

Recommendations for management of vertebral artery stenoses

Recommendations	Class[a]	Level[b]
In patients with symptomatic extracranial vertebral artery stenoses, revascularization may be considered for lesions ≥50% in patients with recurrent ischaemic events despite optimal medical management.[159,160,162]	IIb	B
Revascularization of asymptomatic vertebral artery stenosis is not indicated, irrespective of the degree of severity.	III	C

PAS OU TRES PEU D INDICATION DE REVASCULARISATION

Recommendations on the management of subclavian artery stenosis

Recommendations	Class[a]	Level[b]
In symptomatic patients with subclavian artery stenosis/occlusion, revascularization should be considered.	IIa	C
In symptomatic patients with a stenotic/occluded subclavian artery, both revascularization options (stenting or surgery) should be considered and discussed case by case according to the lesion characteristics and patient's risk.	IIa	C
In asymptomatic subclavian artery stenosis, revascularization:		
• should be considered in the case of proximal stenosis in patients undergoing CABG using the ipsilateral internal mammary artery	IIa	C
• should be considered in the case of proximal stenosis in patients who already have the ipsilateral internal mammary artery grafted to coronary arteries with evidence of myocardial ischaemia	IIa	C
• should be considered in the case of subclavian artery stenosis and ipsilateral arteriovenous fistula for dialysis	IIa	C
• may be considered in the case of bilateral stenosis in order to be able to monitor blood pressure accurately.	IIb	C

Recommendations on the management of acute mesenteric ischaemia

Recommendations	Class[a]	Level[b]
Diagnosis		
In patients with suspected acute mesenteric ischaemia, urgent CTA is recommended.[179]	I	C
In patients with suspicion of acute mesenteric ischaemia, the measurement of D-dimer should be considered to rule out the diagnosis.[178–179]	IIa	B
Treatment		
In patients with acute thrombotic occlusion of the superior mesenteric artery, endovascular therapy should be considered as first-line therapy for revascularization.[182,184,187,188]	IIa	B
In patients with acute embolic occlusion of the superior mesenteric artery, both endovascular and open surgery therapy should be considered.[182,184,187,188]	IIa	B

Plutôt ENDOV

Recommendations for management of chronic mesenteric artery disease

Recommendations	Class[a]	Level[b]
Diagnosis		
In patients with suspected CMI, DUS is recommended as the first-line examination.[193,194]	I	C
In patients with suspected CMI, occlusive disease of a single mesenteric artery makes the diagnosis unlikely and a careful search for alternative causes should be considered.[192,203]	IIa	C
Treatment		
In patients with symptomatic multivessel CMI, revascularization is recommended.[192,195]	I	C
In patients with symptomatic multivessel CMI, it is not recommended to delay revascularization in order to improve the nutritional status.[192,195]	III	C

CHIR OU ENDOV

Recommendations for diagnostic strategies for renal artery disease

Recommendations	Class[a]	Level[b]
DUS (as first-line), CTA[c] and MRA[d] are recommended imaging modalities to establish a diagnosis of RAD.[204,212]	I	B
DSA may be considered to confirm a diagnosis of RAD when clinical suspicion is high and the results of non-invasive examinations are inconclusive.[212,215]	IIb	C
Renal scintigraphy, plasma renin measurements before and after ACEI provocation and vein renin measurements are not recommended for screening of atherosclerotic RAD.[204]	III	C

Recommendations for treatment strategies for renal artery disease

Recommendations	Class[a]	Level[b]
Medical therapy		
ACEIs/ARBs are recommended for treatment of hypertension associated with unilateral RAS.[219–222,240]	I	B
Calcium channel blockers, beta-blockers and diuretics are recommended for treatment of hypertension associated with renal artery disease.	I	C
ACEIs/ARBs may be considered in bilateral severe RAS and in the case of stenosis in a single functioning kidney, if well-tolerated and under close monitoring.[219,221]	IIb	B

ABANDON DE L'ANGIOPLASTIE!!!!!
Sauf pour LA FIBRODYSPLASIE

Revascularization		
Routine revascularization is not recommended in RAS secondary to atherosclerosis.[229,231,232]	III	A
In cases of hypertension and/or signs of renal impairment related to renal arterial fibromuscular dysplasia, balloon angioplasty with bailout stenting should be considered.[234–236]	IIa	B
Balloon angioplasty, with or without stenting, may be considered in selected patients with RAS and unexplained recurrent congestive heart failure or sudden pulmonary oedema.[229,237,238]	IIb	C
In the case of an indication for revascularization, surgical revascularization should be considered for patients with complex anatomy of the renal arteries, after a failed endovascular procedure or during open aortic surgery.[241–243]	IIa	B

2010 LE GRAND SHISME!!!!

vascular NEWS INTERNATIONAL

Issue 60 November 2013

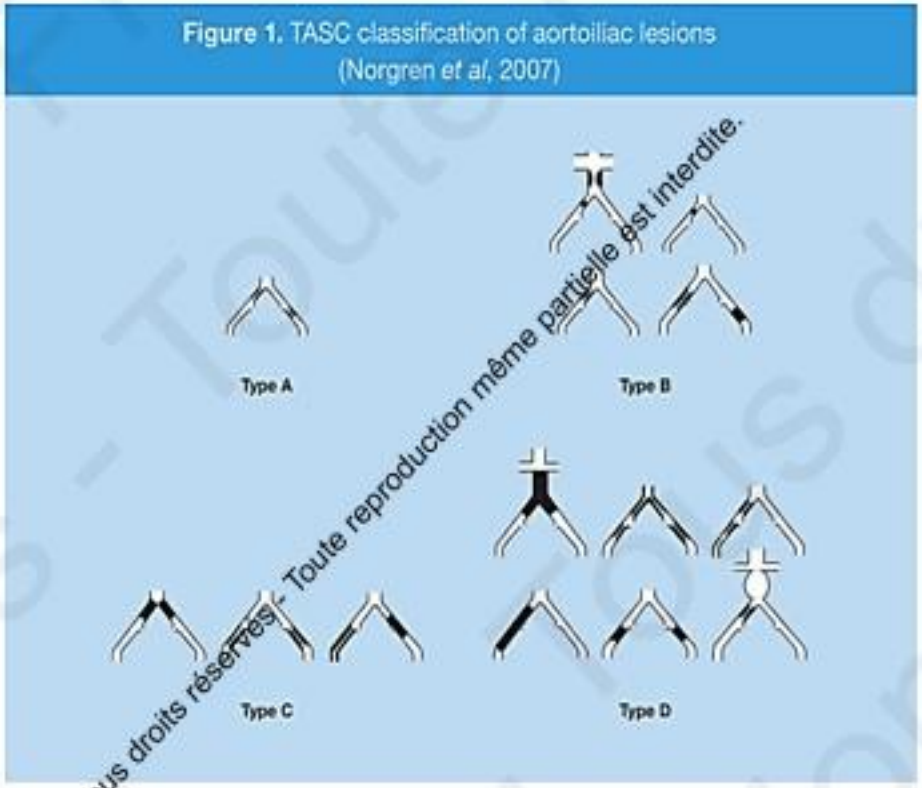
Vascular surgery societies refuse to endorse TASC III

Vascular News **has learnt that the World Federation of Vascular Societies has decided to drop out of the Inter-Society Consensus for the Management of Peripheral Artery Disease (TASC) III. The process to develop the update began in 2011, and the TASC committee initially planned to submit the new guidelines for publication in 2013. However, the surgical societies question the evidence behind TASC III and have decided to develop their own guidelines, the ISVaC global consensus**

John Wolfe, London, UK, immediate past president of the World Federation of Vascular Societies (WFVS), told *Vascular News*: "The European Society for Vas-

cannot write guidelines resting on 'this is the best thing to do, so we will put that in the guidelines'."

Michael Jaff, Boston, USA, chair of the TASC Steering Committe, said:



Classification TASC basée exclusivement sur l'anatomie

Inter-Society Consensus for the Management of PAD

Result of cooperation between fourteen medical and surgical vascular, cardiovascular, vascular radiology and cardiology societies in Europe and North America

6 AU 8 DÉCEMBRE 2017
Novotel Paris Tour Eiffel
Passion Communication Education

TASC III 2010 Jamais publié!!!!

TASC

- TASC 2000
  - Type A
    - Endovascular treatment
  - Type D
    - Surgical treatment
  - Type B/C
    - Dependent on operator skills/preference
- TASC II
  - Type A/D unchanged
  - Type B
    - Endovascular treatment
  - Type C
    - surgery is the preferred treatment for good-risk patients
  - The patient's co-morbidities, fully informed patient preference and the local operator's long-term success rates must be considered when making treatment recommendations for type B and type C lesions

    (not all stents are equal, but also not all operators are equal)

Norgren L et al, EJVES 2007;33:S1-S75

Supprimer les pontages ?

TASC A, B, C and D lesions in the aorto-iliac segments of patients with symptomatic PAD should be initially treated with endovascular therapy [Grade B].

2017 NEW / REVISED CONCEPTS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EXIT LE TASC ET LE CONCEPT D'ISCHEMIE CRITIQUE (IC),

remplacé par celui de

« Chronic Limb-Threatening Ischemia »!!(CLTI)

Définition de l'IC: 1982 , uniquement sous l'angle de la perfusion, excluant les diabétiques

2017 estimated current prevalence rates of neuropathic, ischemic, and neuroischemic ulcers in patients with diabetes are 35%, 15%, and 50%, respectively.

A New Classification System for the Threatened Lower Limb: SVS WIfI

Joseph L. Mills, Sr., M.D.
Professor of Surgery, Chief, Vascular & Endovascular Surgery
University of Arizona Health Sciences Center
Co-Director, SALSA (Southern Arizona Limb Salvage Alliance)

SOCIETY FOR VASCULAR SURGERY® DOCUMENT

The Society for Vascular Surgery Lower Extremity Threatened Limb Classification System: Risk stratification based on Wound, Ischemia, and foot Infection (WIfI)

(J Vasc Surg 2014;59:220-34.)

Recommendations for the management of patients with intermittent claudication

Recommendations	Class[a]	Level[b]
On top of general prevention, statins are indicated to improve walking distance.[30,278]	I	A
In patients with intermittent claudication:		
• supervised exercise training is recommended[273,287–289]	I	A
• unsupervised exercise training is recommended when supervised exercise training is not feasible or available.	I	C
When daily life activities are compromised despite exercise therapy, revascularization should be considered.	IIa	C
When daily life activities are is severely compromised, revascularization should be considered in association with exercise therapy.[288,290]	IIa	B

Recommendations on revascularization of aorto-iliac occlusive lesions[c]

Recommendations	Class[a]	Level[b]
An endovascular-first strategy is recommended for short (i.e. <5 cm) occlusive lesions.[291]	I	C
In patients fit for surgery, aorto-(bi)femoral bypass should be considered in aorto-iliac occlusions.[281,292,293]	IIa	B
An endovascular-first strategy should be considered in long and/or bilateral lesions in patients with severe comorbidities.[288,294,295]	IIa	B
An endovascular-first strategy may be considered for aorto-iliac occlusive lesions if done by an experienced team and if it does not compromise subsequent surgical options.[76,281–283,286]	IIb	B
Primary stent implantation rather than provisional stenting should be considered.[294–296]	IIa	B
Open surgery should be considered in fit patients with an aortic occlusion extending up to the renal arteries.	IIa	C
In the case of ilio-femoral occlusive lesions, a hybrid procedure combining iliac stenting and femoral endarterectomy or bypass should be considered.[297–300]	IIa	C
Extra-anatomical bypass may be indicated for patients with no other alternatives for revascularization.[301]	IIb	C

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Recommendations on revascularization of femoro-popliteal occlusive lesions[c]

Recommendations	Class[a]	Level[b]
An endovascular-first strategy is recommended in short (i.e. <25 cm) lesions.[302,303]	I	C
Primary stent implantation should be considered in short (i.e. <25 cm) lesions.[304,305]	IIa	A
Drug-eluting balloons may be considered in short (i.e. <25 cm) lesions.[77,306–310]	IIb	A
Drug-eluting stents may be considered for short (i.e. <25 cm) lesions.[302,303,311]	IIb	B
Drug-eluting balloons may be considered for the treatment of in-stent restenosis.[312,313]	IIb	B
In patients who are not at high risk for surgery, bypass surgery is indicated for long (i.e. ≥25 cm) superficial femoral artery lesions when an autologous vein is available and life expectancy is >2 years.[314]	I	B
The autologous saphenous vein is the conduit of choice for femoro-popliteal bypass.[284,315]	I	A
When above-the-knee bypass is indicated, the use of a prosthetic conduit should be considered in the absence of any autologous saphenous vein.[284]	IIa	A
In patients unfit for surgery, endovascular therapy may be considered in long (i.e. ≥25 cm) femoro-popliteal lesions.[312]	IIb	C

< 25 CM : ENDOV

>25 CM: PONTAGE VEINEUX (ENDOV SI RISQUE CHIR HAUT)

DES ET DEB : PAS LA COTE.....(II b B)

« Chronic Limb-Threatening Ischemia »!!(CLTI)

Table 7 Assessment of the risk of amputation: the WIFI classification (for further details see Mills et *al*[317])

Component	Score	Description		
W (Wound)	0	No ulcer (ischaemic rest pain)		
	1	Small, shallow ulcer on distal leg or foot without gangrene		
	2	Deeper ulcer with exposed bone, joint or tendon ± gangrenous changes limited to toes		
	3	Extensive deep ulcer, full thickness heel ulcer ± calcaneal involvement ± extensive gangrene		
I (Ischaemia)		ABI	Ankle pressure (mmHg)	Toe pressure or $TcPO_2$
	0	≥0.80	> 100	≥60
	1	0.60–0.79	70–100	40–59
	2	0.40–0.59	50–70	30–39
	3	<0.40	<50	<30
fI (foot Infection)	0	No symptoms/signs of infection		
	1	Local infection involving only skin and subcutaneous tissue		
	2	Local infection involving deeper than skin/subcutaneous tissue		
	3	Systemic inflammatory response syndrome		

Example: A 65-year-old male diabetic patient with gangrene of the big toe and a <2 cm rim of cellulitis at the base of the toe, without any clinical/biological sign of general infection/inflammation, whose toe pressure is at 30 mmHg would be classified as Wound 2, Ischaemia 2, foot Infection **1** (WIfI 2-2-1). The clinical stage would be 4 (high risk of amputation). The benefit of revascularization (if feasible) is high, also depending on infection control.

Idée: classification type TNM d'oncologie

Risk/benefit: Clinical stages by expert consensus

a, Estimate risk of amputation at 1 year for each combination

	Ischemia – 0				Ischemia – 1				Ischemia – 2				Ischemia – 3			
W-0	VL	VL	L	M	VL	L	M	H	L	L	M	H	L	M	M	H
W-1	VL	VL	L	M	L	L	M	H	L	M	H	H	M	M	H	H
W-2	L	L	M	H	M	M	H	H	M	H	H	H	H	H	H	H
W-3	M	M	H	H	H	H	H	H	H	H	H	H	H	H	H	H
	fl-0	fl-1	fl-2	fl-3	fl-0	fl-1	fl-2	fl-3	fl-0	fl-1	fl-2	fl-3	fl-0	fl-1	fl-2	fl-3

b, Estimate likelihood of benefit of/requirement for revascularization (assuming infection can be controlled first)

	Ischemia – 0				Ischemia – 1				Ischemia – 2				Ischemia – 3			
W-0	VL	VL	VL	VL	VL	L	L	M	L	L	M	M	M	H	H	H
W-1	VL	VL	VL	VL	L	M	M	M	M	H	H	H	H	H	H	H
W-2	VL	VL	VL	VL	M	M	H	H	H	H	H	H	H	H	H	H
W-3	VL	VL	VL	VL	M	M	M	H	H	H	H	H	H	H	H	H
	f-0	fl-1	fl-2	fl-3	fl-0	fl-1	fl-2	fl-3	fl-0	fl-1	fl-2	fl-3	fl-0	fl-1	fl-2	fl-3

fl, foot Infection; I, Ischemia; W, Wound.

Very low = VL = clinical stage 1
Low = L = clinical stage 2
Moderate = M = clinical stage 3
High = H = clinical stage 4
Clinical stage 5 would signify an unsalvageable foot

Ischemia 2 foot infection 1 or WIfI 221.

IV. Stages: The four clinical stages were derived by Delphi Consensus (Table IV.) and will require prospective validation. This process is intended to be iterative and is meant to reduce the number of clinical stages to a manageable and meaningful number; the stages should correlate with amputation risk (natural history of limb with that given clinical stage in the absence of revascularization). Using the same patient examples as above:

Recommendations on the management of chronic limb-threatening ischaemia

Recommendations	Class[a]	Level[b]
Early recognition of tissue loss and/or infection and referral to the vascular team is mandatory to improve limb salvage.[317]	I	C
In patients with CLTI, assessment of the risk of amputation is indicated.[317]	I	C
In patients with CLTI and diabetes, optimal glycaemic control is recommended.[318,319]	I	C
For limb salvage, revascularization is indicated whenever feasible.[314]	I	B
In CLTI patients with below-the-knee lesions, angiography including foot runoff should be considered prior to revascularization.	IIa	C
In patients with CLTI, stem cell/gene therapy is not indicated.[328]	III	B

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Recommendations on revascularization of infra-popliteal occlusive lesions

Recommendations	Class[a]	Level[b]
In the case of CLTI, infra-popliteal revascularization is indicated for limb salvage.[320–326]	I	C
For revascularization of infra-popliteal arteries:		
• bypass using the great saphenous vein is indicated	I	A
• endovascular therapy should be considered.[320–326]	IIa	B

OUPS!!! BYPASS plutôt qu' ENDOVASCULAIRE.....

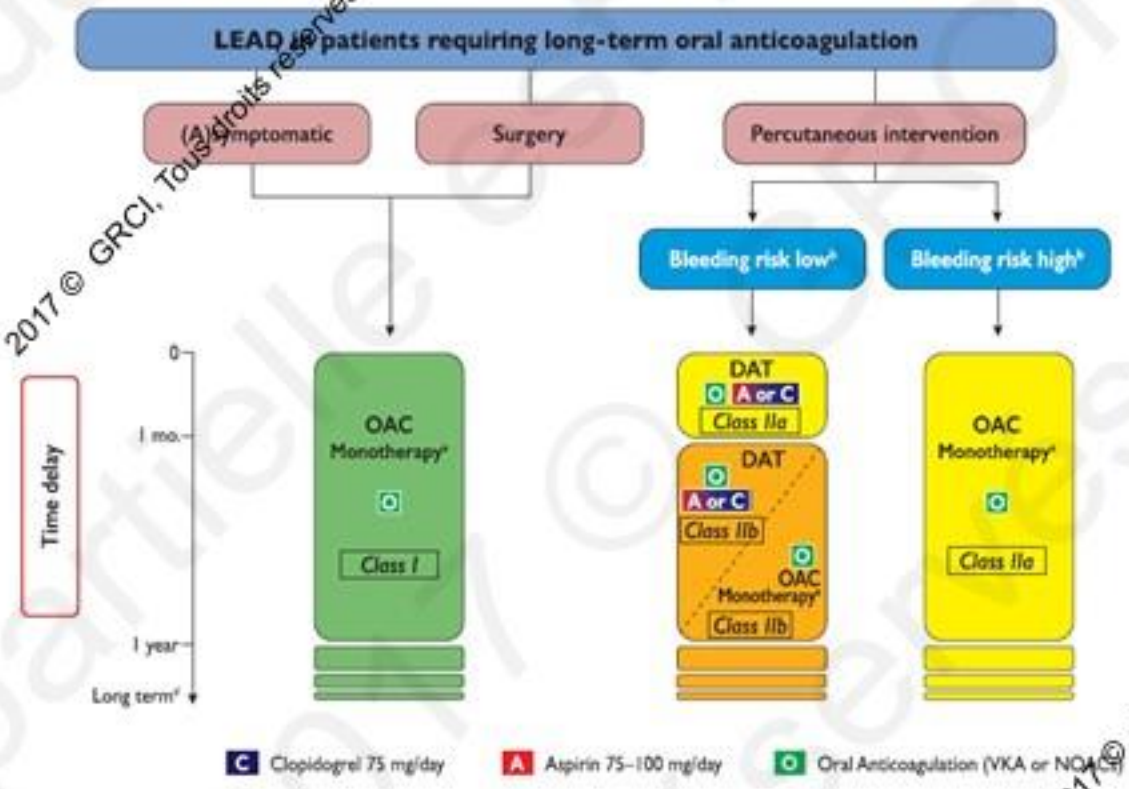
TRAITEMENT ANTITHROMBOTIQUE

Recommendations on antithrombotic therapy in patients with peripheral arterial diseases

Recommendations	Class[a]	Level[b]
Carotid artery disease		
In patients with symptomatic carotid stenosis, long-term SAPT is recommended (87).	I	A
DAPT with aspirin and clopidogrel is recommended for at least 1 month after CAS (60).	I	B
In patients with asymptomatic >50% carotid artery stenosis, long-term antiplatelet therapy (commonly low-dose aspirin) should be considered when the bleeding risk is low.[c]	IIa	C
Lower extremities artery disease		
Long-term SAPT is recommended in symptomatic patients.[51,54,68]	I	A
Long-term SAPT is recommended in all patients who have undergone revascularization.[72]	I	C
SAPT is recommended after infra-inguinal bypass surgery.[72,88,89]	I	A
In patients requiring antiplatelet therapy, clopidogrel may be preferred over aspirin.[51,69]	IIb	B
Vitamin K antagonists may be considered after autologous vein infra-inguinal bypass.[73]	IIb	B
DAPT with aspirin and clopidogrel for at least 1 month should be considered after infra-inguinal stent implantation.	IIa	C
DAPT with aspirin and clopidogrel may be considered in below-the-knee bypass with a prosthetic graft.[64]	IIb	B
Because of a lack of proven benefit, antiplatelet therapy is not routinely indicated in patients with isolated[d] asymptomatic LEAD.[66, 67]	III	A

BITHERAPIE ANTIAGREGANTE 1 MOIS PUIS MONOTHERAPIE APRES ANGIOPLASTIE SOUS INGUINALE OU CAROTIDE

Antithrombotic therapy for PADs patients requiring oral anticoagulant		
In patients with PADs and AF, OAC:[83,90] • is recommended when the CHA_2DS_2-VASc score is ≥ 2 • should be considered in all other patients.	I	A
	IIa	B
In patients with PADs who have an indication for OAC (e.g. AF or mechanical prosthetic valve), oral anticoagulants alone should be considered.[91]	IIa	B
After endovascular revascularization, aspirin or clopidogrel should be considered in addition to OAC for at least 1 month if the bleeding risk is low compared with the risk of stent/graft occlusion.	IIa	C
After endovascular revascularization, OAC alone should be considered if the bleeding risk is high compared with the risk of stent/graft occlusion.	IIa	C
OAC and SAPT may be considered beyond 1 month in high ischaemic risk patients or when there is another firm indication for long-term SAPT.	IIb	C



EVITER LA TRITHERAPIE

CONCLUSIONS

- Réduction des indications de revascularisation chez l'asymptomatique avec une sténose carotide, petite ouverture pour **l'ENDOVASCULAIRE…**
- Vision ,plutôt **CARDIOLOGIQUE,** du traitement antithrombotique associé ….
- Vision ,plutôt **CHIRURGICALE TRADITIONNELLE** (voire « réactionnaire » …..) de la revascularisation …