Gestion du patient coronarien très agé (Haut risque hémorragique) Quelle DAPT au décours ?

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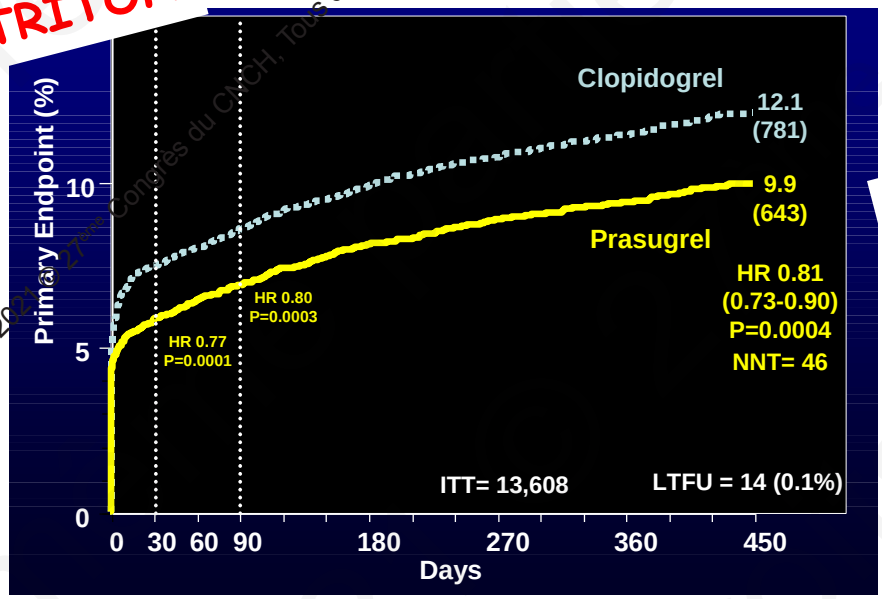
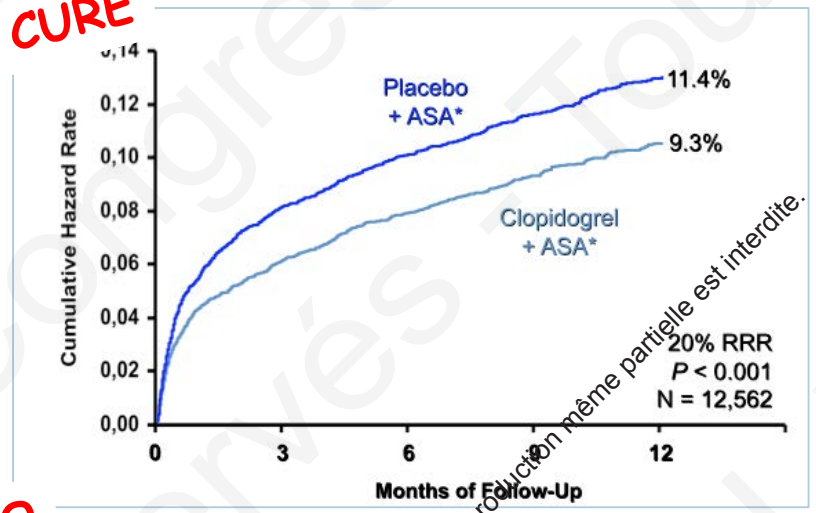
Ce que l'on savait …

- At least 12 months …

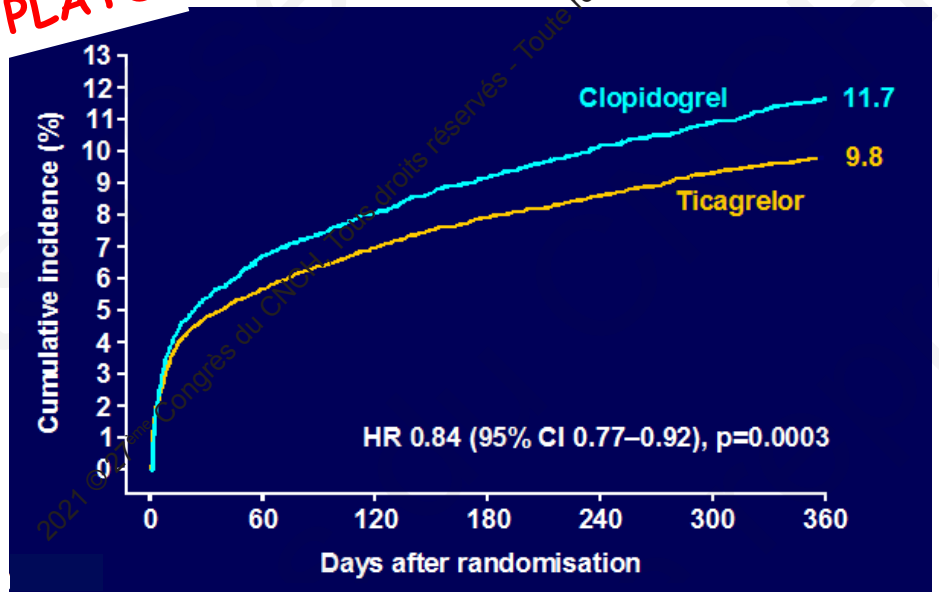
TRITON



CURE



PLATO

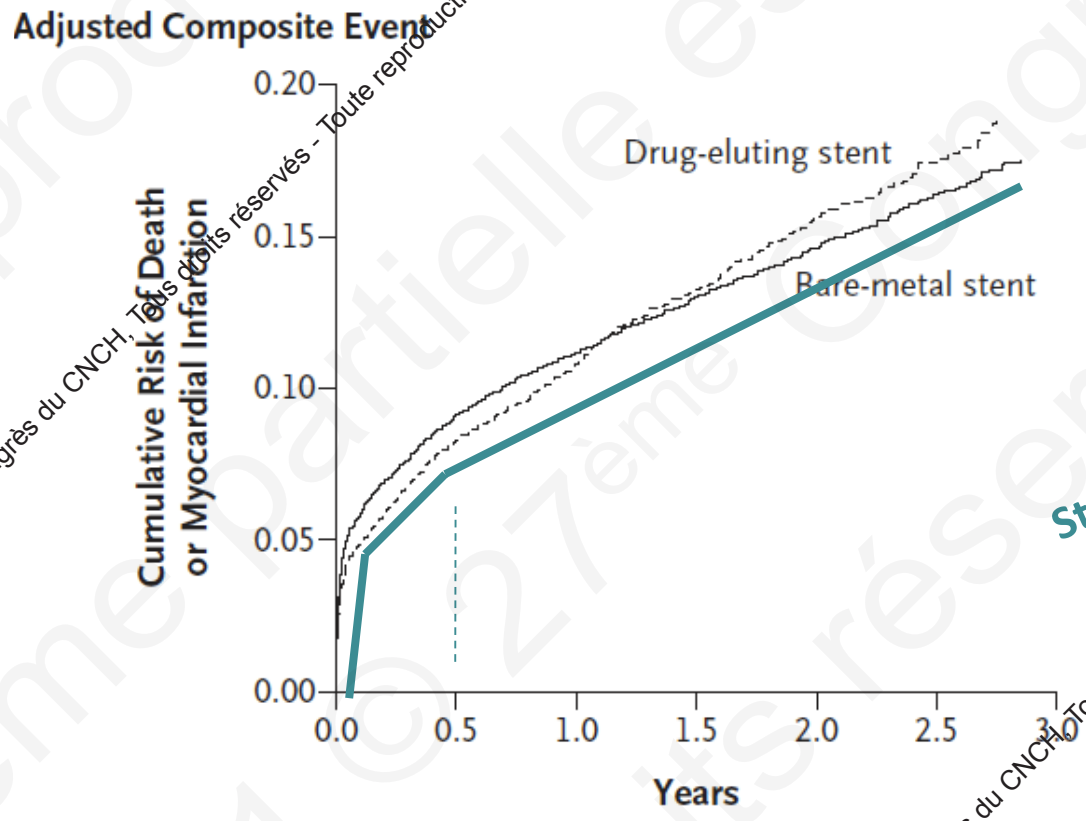


Problèmes du sujet âgé

- Nombreuses co-morbidités
  - Risque d'évènement ischémique accru
  - Risque hémorragique accru
  - Insuffisance rénale => Risque de surdosage/accumulation des traitements
  - Anémie
  - Fragilité vasculaire
  - Forte prévalence de la FA et nécessité d'anticoagulation

- Lésions coronaires plus complexes (calcifications, atteinte diffuse, ...)

Natural history after an acute coronary event



No. at Risk

Bare-metal stent	12,880	11,706	11,432	8665	5520	2963	7
Drug-eluting stent	5,770	5,307	5,158	3216	1608	580	0

Stability at 6 months !!!

Lagerqvist et al. NEJM 2007 SCAAR Registry

L'arrêt précoce de la DAPT

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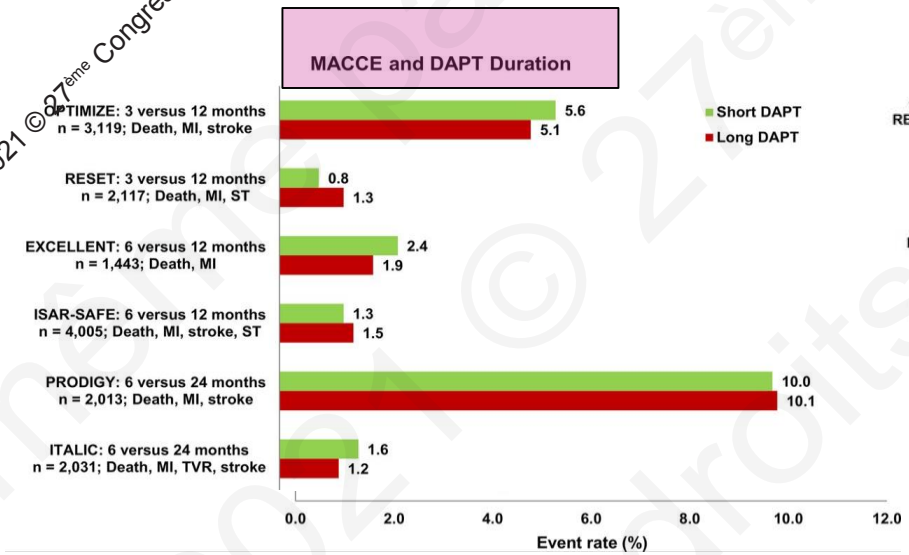
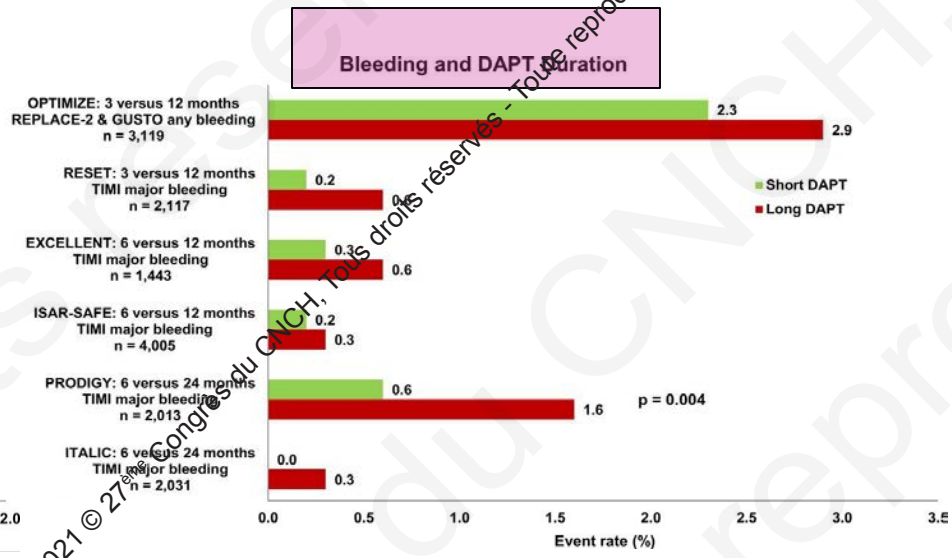
Randomized studies

- EXCELLENT (1443 patients – 6 mois vs 12 mois) ≈50% IDM
- OPTIMIZE (3119 patients – 3 mois vs 12 mois) ≈ 5% IDM
- RESET (2148 patients – 3 mois vs 12 mois) ≈15% IDM
- PRODIGY (2013 patients – 6 vs 24 mois) ≈50% IDM
- ISAR-SAFE (4005 patients – 6 mois vs $9_{/12}$ mois) ≈20% IDM
- ITALIC (2031 patients – 6 mois vs $12_{/24}$ mois) ≈7% IDM
- SECURITY (1404 patients – 6 mois vs 12 mois) => Aucun IDM
- I-LOVE-IT-2 (1829 patients – 6 mois vs 12 mois) ≈25% IDM
- IVUS-XPL (1400 patients – 6 mois vs 12 mois) ≈15% IDM
- NIPPON (3773 patients – 6 mois vs 18 mois) ≈15% IDM
- SMART-DATE (2712 patients – 6 mois vs 12 mois) ≈70% IDM
- MASTER-DAPT (2913 patients in the no-OAC group – 1 mois vs 12 mois) ≈30% IDM





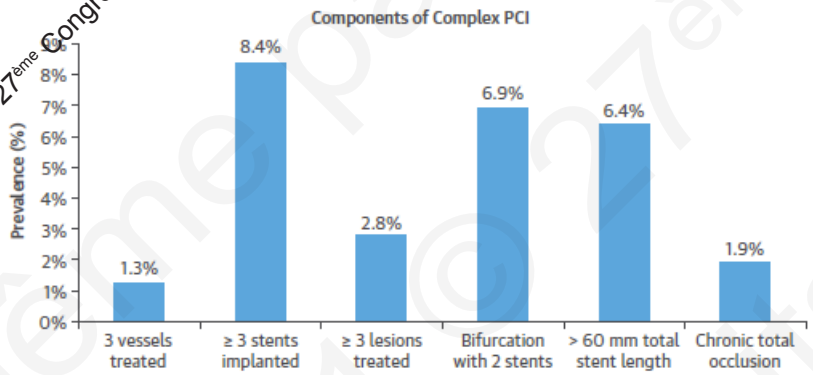
Binder et al. Eur Heart J 2015;36:1207-1211

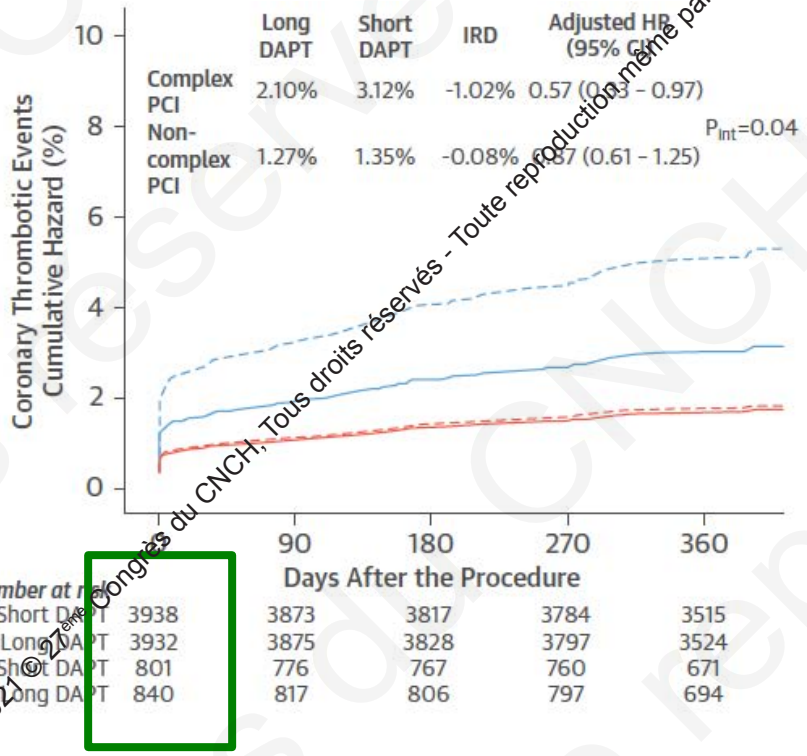
The low residual ischemic risk

Risk of coronary thrombotic events

A meta-analysis of 6 Studies

- SECURITY
- PRODIGY
- ITALIC
- EXCELLENT
- OPTIMIZE
- RESET

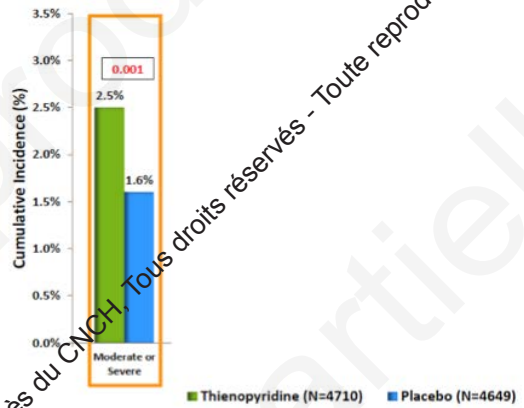




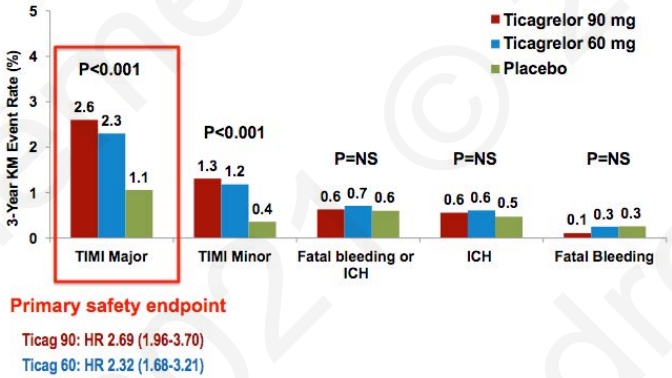
Giustino et al. J Am Coll Cardiol 2016;68:1851–64

Higher risk of bleeding if DAPT is pursued after 12 months

The DAPT trial



The PEGASUS trial



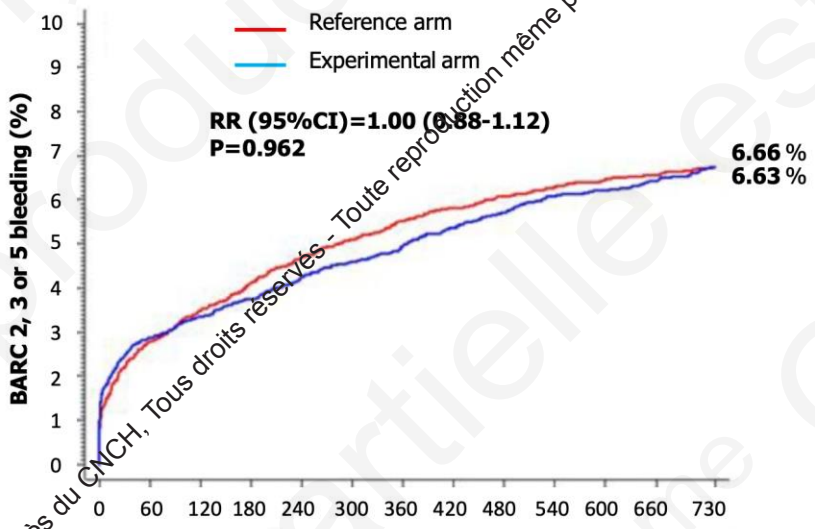
The COMPASS trial

Outcome	R + A N=9,152 N (%)	R N=9,117 N (%)	A N=9,126 N (%)	Rivaroxaban + Aspirin vs. Aspirin HR (95% CI)	P	Rivaroxaban vs. Aspirin HR (95% CI)	P
Major bleeding	288 (3.1%)	255 (2.8%)	170 (1.9%)	1.70 (1.40-2.05)	<0.0001	1.51 (1.25-1.84)	<0.0001
Fatal	15 (0.2%)	14 (0.2%)	10 (0.1%)	1.49 (0.67-3.33)	0.32	1.40 (0.62-3.15)	0.41
Non fatal ICH*	21 (0.2%)	32 (0.4%)	19 (0.2%)	1.10 (0.59-2.04)	0.77	1.69 (0.96-2.98)	0.07
Non-fatal other critical organ*	42 (0.5%)	45 (0.5%)	29 (0.3%)	1.43 (0.89-2.29)	0.14	1.57 (0.98-2.50)	0.06

* symptomatic

GLOBAL LEADERS

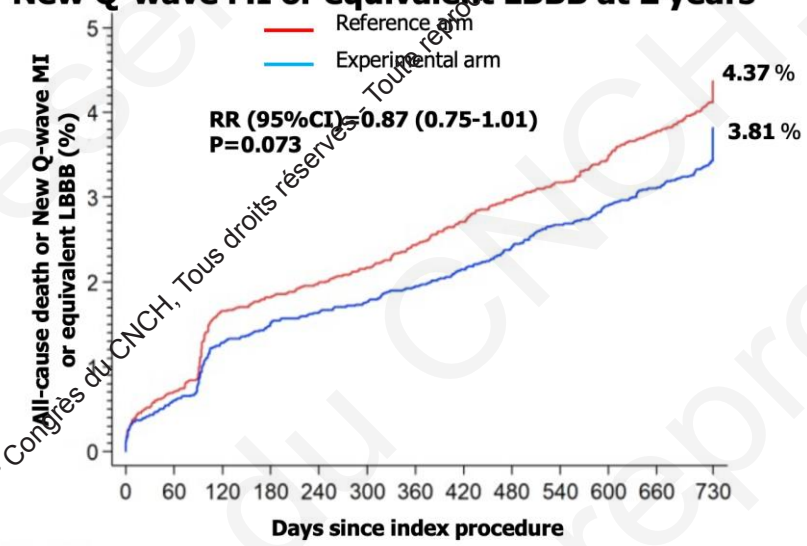
Kaplan Meier estimate of BARC 2, 3 or 5 bleeding at 2 years



Number at risk

Reference	7988	7686	7596	7535	7473	7430	7374	7328	7291	7259	7233	7203	7125
Experimental	7980	7640	7568	7523	7466	7430	7389	7332	7286	7240	7201	7170	7047

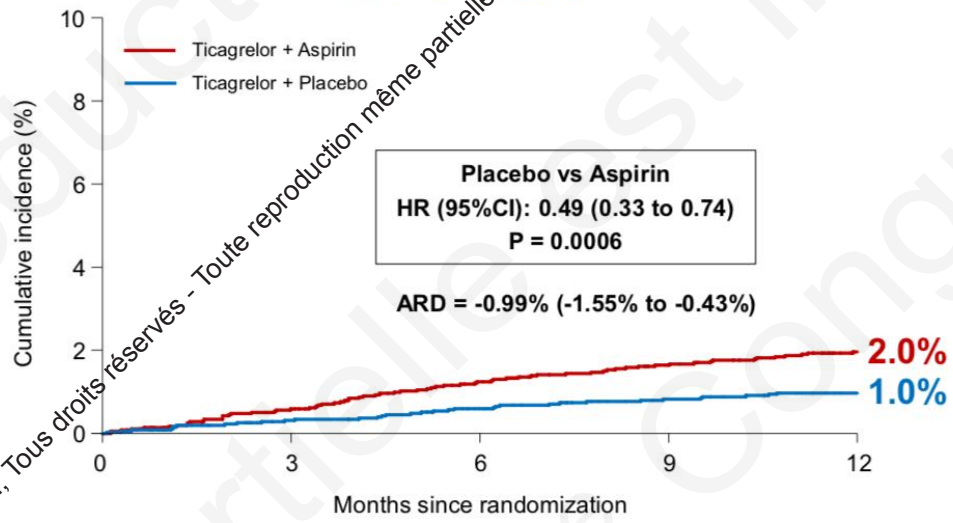
Kaplan Meier estimate of all-cause death or New Q-wave MI or equivalent LBBB at 2 years



Number at risk

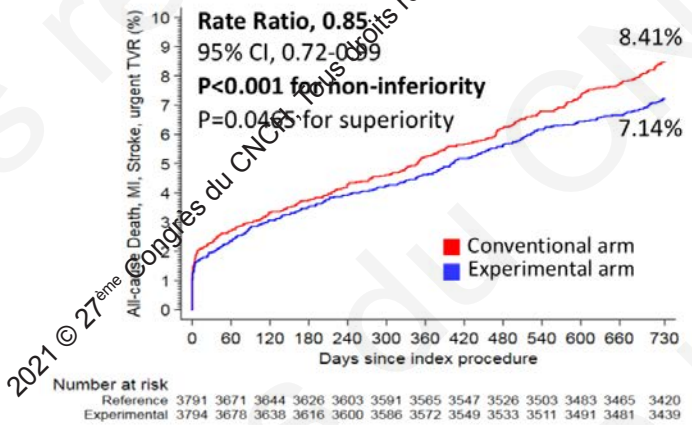
Reference	7988	7930	7854	7841	7827	7813	7792	7768	7747	7729	7706	7680	7610
Experimental	7980	7927	7873	7856	7843	7833	7819	7802	7780	7759	7739	7722	7626

BARC 3 or 5 Bleeding
ITT Cohort



No. at risk					
Ticagrelor + Aspirin	3564	3516	3470	3426	3390
Ticagrelor + Placebo	3555	3504	3475	3440	3423

ISCHAEMIC ENDPOINT



Number at risk

Reference	3791	3671	3644	3626	3603	3591	3585	3547	3526	3503	3483	3465	3420
Experimental	3794	3678	3638	3616	3600	3586	3572	3549	3533	3511	3491	3481	3439

La dé-escalation

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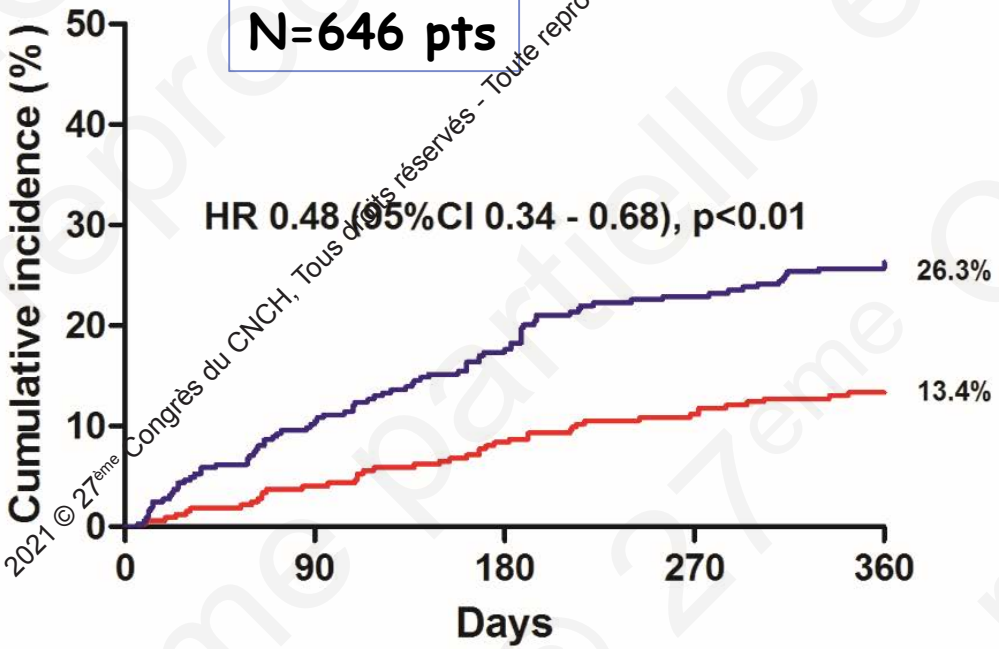
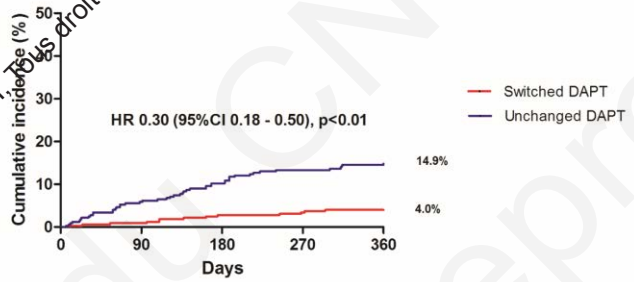
Primary Endpoint

Death, Urgent revasc., Stroke, BARC ≥ 2

N=646 pts

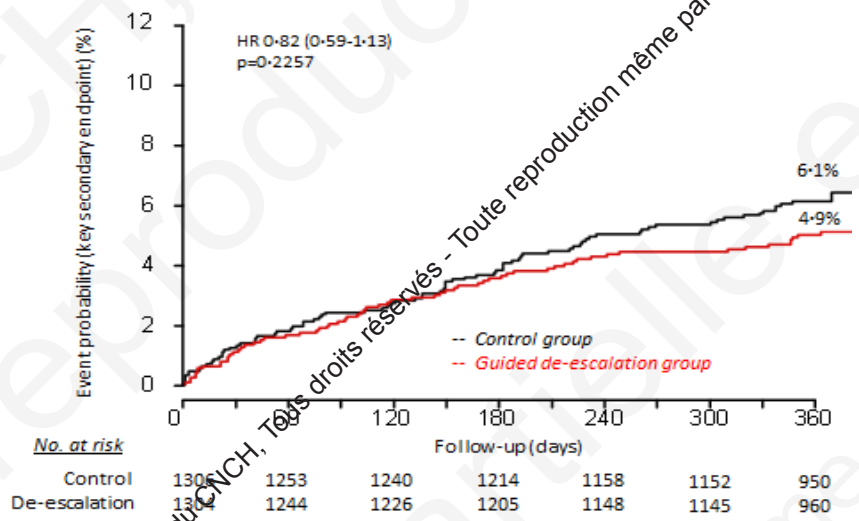


BARC bleedings ≥ 2

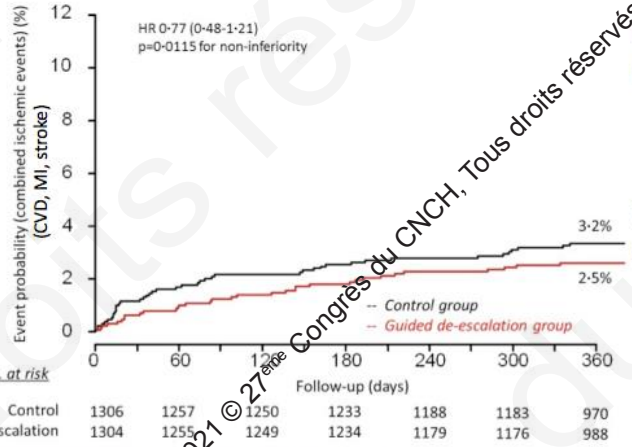


ENDPOINTS	Switched DAPT (n=322)	Unchanged DAPT (n=323)	HR (95%IC)	P-value
TIMI Major	1 (0.3%)	4 (1.2%)	0.30 (0.05 - 1.73)	0.18

Key Secondary endpoint
Bleeding BARC ≥2

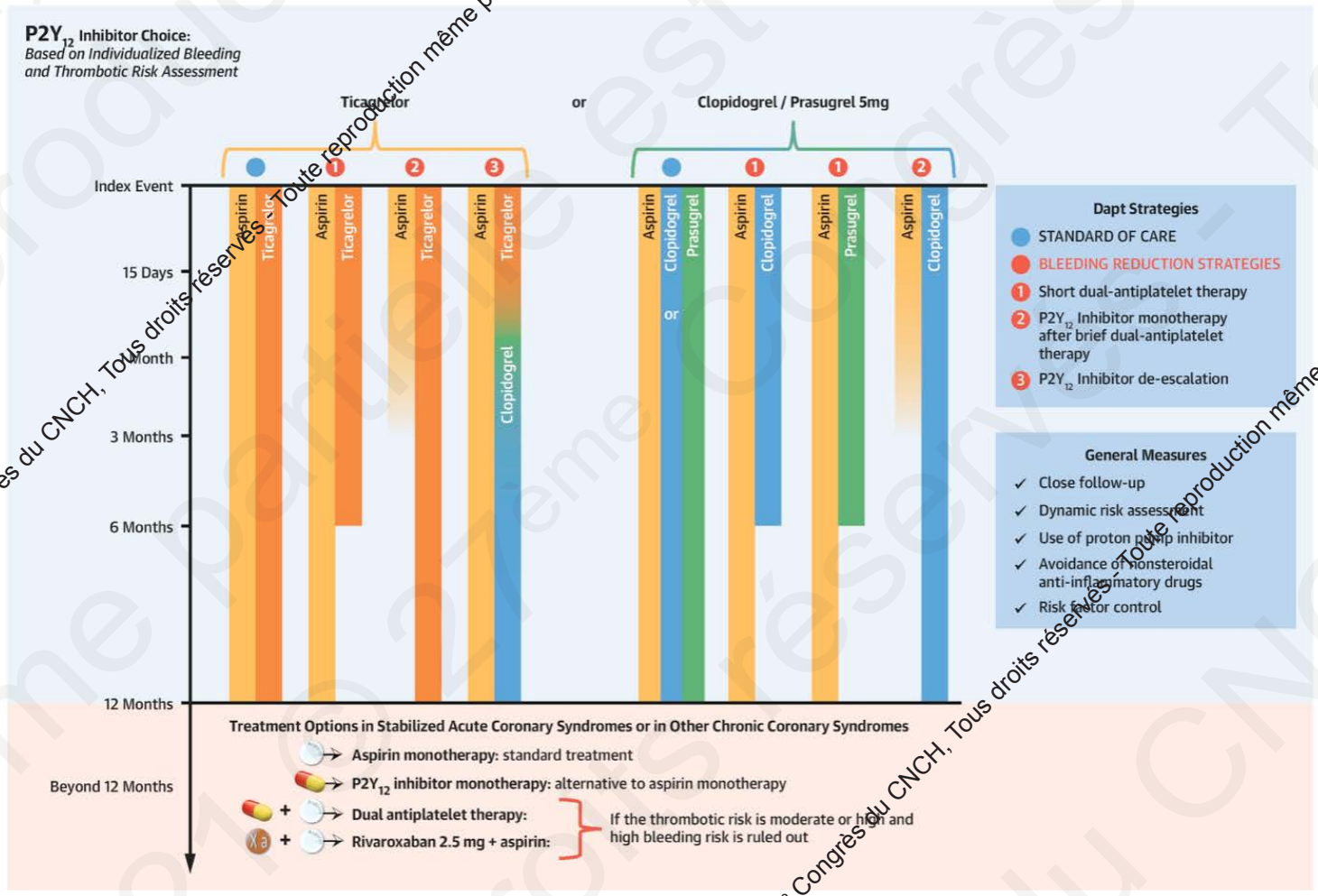


Ischemic events at 12 months follow-up

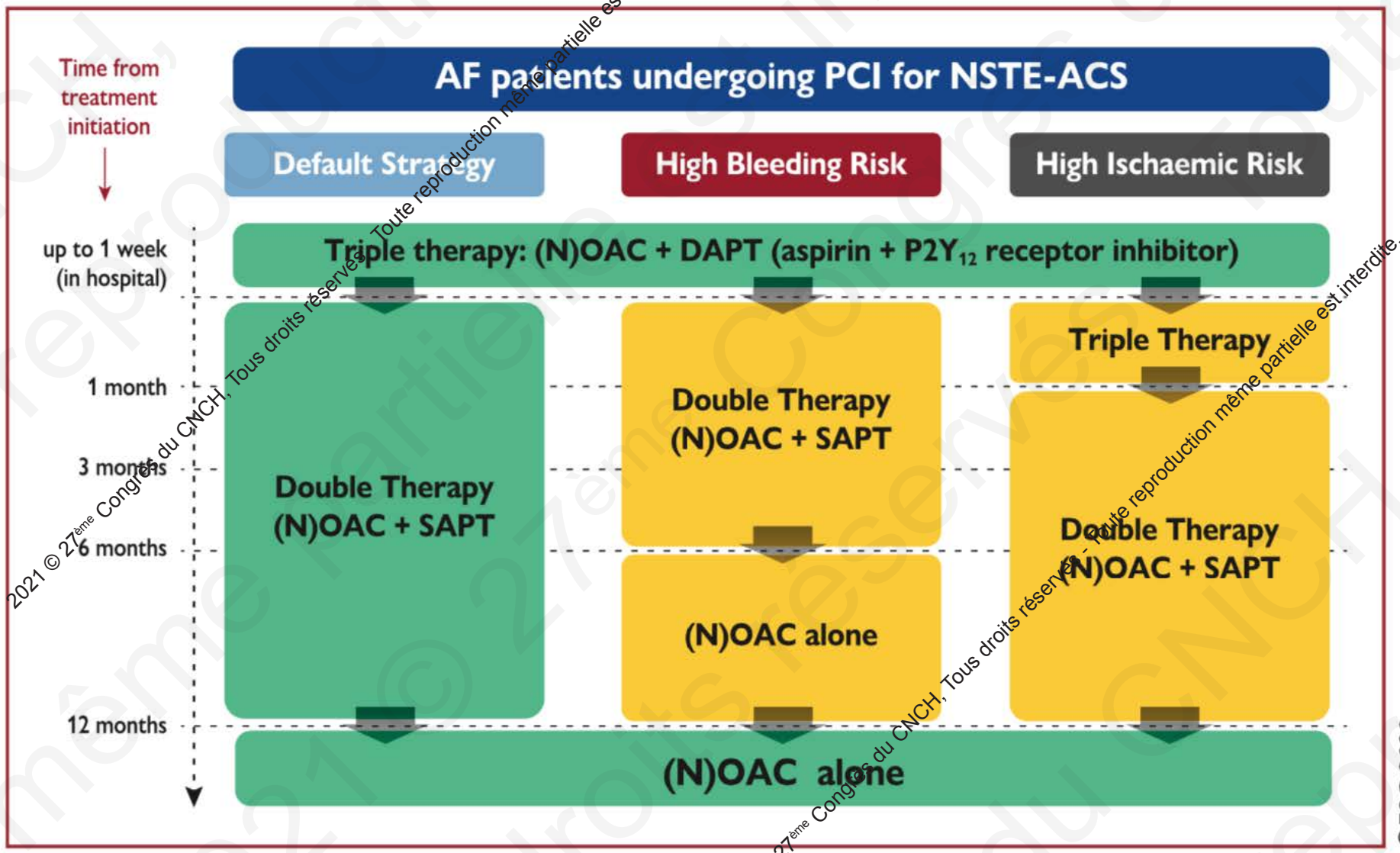


- All-cause mortality:
  12 events (1%) in control vs. 11 (1%) in guided de-escalation group, p=0.85
- Definite ST:
  3 events (0.2%) in control vs. 2 (0.2%) in guided de-escalation group, p=0.66

CENTRAL ILLUSTRATION: Antithrombotic Strategies to Minimize the Risk for Bleeding in Elderly Patients With Acute Coronary Syndromes



Capranzano, P. et al. J Am Coll Cardiol Intv. 2021;14(7):723-38.



Conclusion

- The discharge letter must mentioned the initial strategy that relies on the interventional cardiologist decision
  - 3-6 months for scheduled PCI
  - 12 months in case of ACS

  } The default strategy

- If there is a necessity to shorten (in case of high risk bleeding)
  - It should be mentioned why in the discharge letter, and when stop DAPT
  - In case of long-term oral anticoagulation, the discharge letter should precise what would be the strategy in the early following months

- DAPT duration must be re-evaluated at each visit (Tolerance)

- Encore des études à venir … TARGET-FIRST

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