Constats de la prise en charge du patient post-SCA dès l'USIC

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FACT: French Alliance for Cardiovascular clinical Trials

Liens d'intérêts

- **Bourses de recherche :** Abbott, Astra-Zeneca, Bayer
- **Honoraires (orateur ou consultant) :** Abbott, Amgen, Astra-Zeneca, BMS, Bayer, Biotronik, Boehringer Ingelheim, Daiichi-Sankyo, Lilly, MSD, Novartis, Pfizer, Sanofi, Servier

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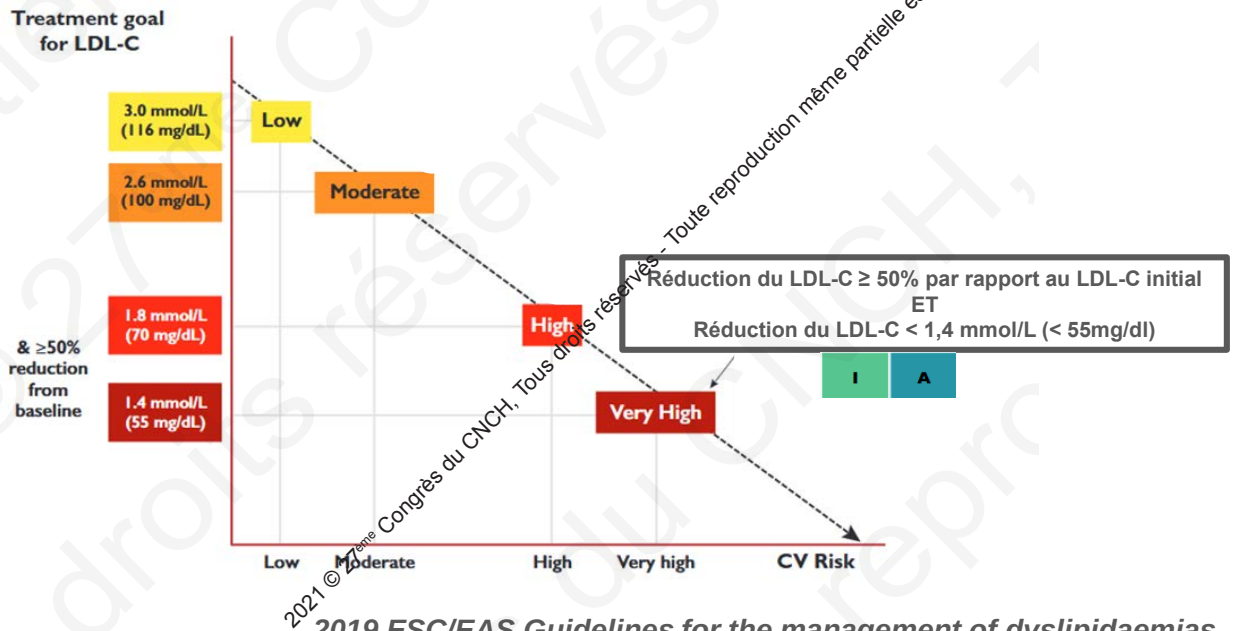
Des recommandations à la pratique clinique …

Recommendations for lipid-lowering therapy in very-high-risk patients with acute coronary syndromes

Recommendations	Class[a]	Level
In all ACS patients without any contraindication or definite history of intolerance, it is recommended that high-dose statin therapy is initiated or continued as early as possible, regardless of initial LDL-C values.[438,440,442]	I	A

SCA = Patients à très haut risque



2019 ESC/EAS Guidelines for the management of dyslipidaemias

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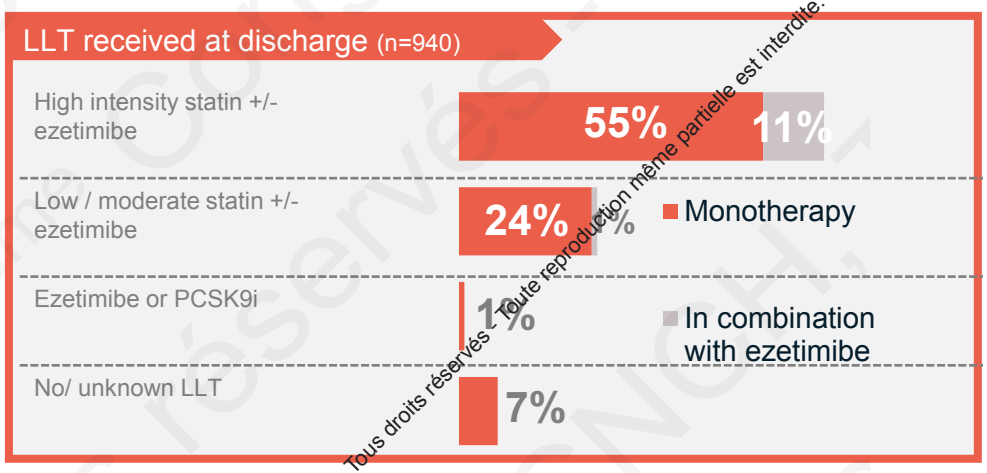
ACS EURO PATH



66% high-intensity statins
25% moderate-low intensity statins
11% combination high-intensity statins + ezetimibe
Few (2%) combination moderate-low intensity + ezetimibe or ezetimibe alone

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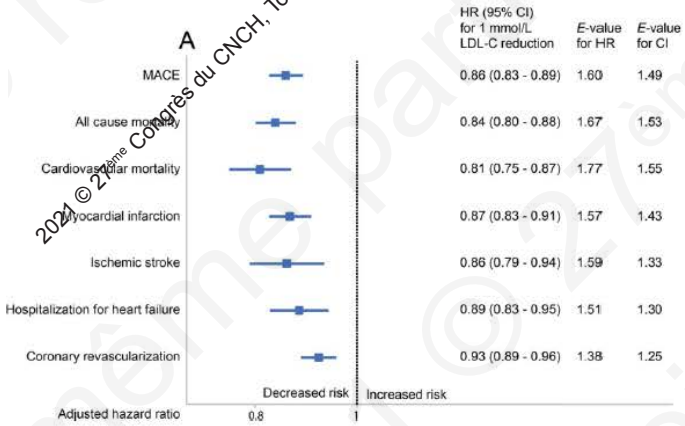
	STEMI n=2620	NSTEMI n=2971	AMI n=5140
LDL-C	1.21 ± 0.43 g/L	1.13 ± 0.43 g/L	1.17 ± 0.43 g/L
High dose statin	1350 (53%)	902 (34.6%)	2252 (43.7%)
Statin + ezetimibe	51 (2%)	100 (3.8%)	151 (2.5%)
Ezetimibe alone	59 (2.3%)	129 (5%)	188 (3.6%)

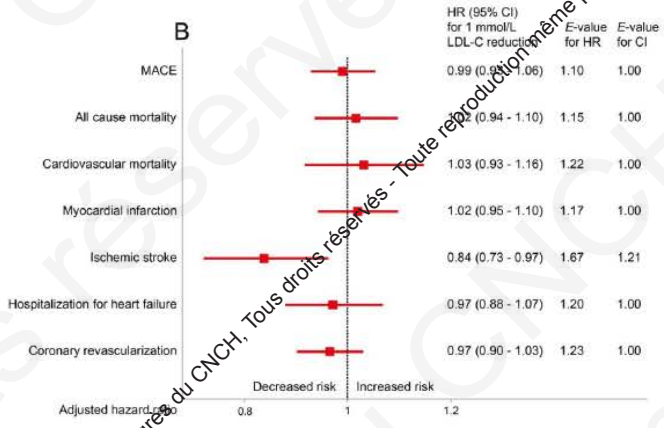
Des recommandations à la pratique clinique …

	Statin naive	Ongoing statin
Number of patients	31,263	9344
LDL-C in mmol/L at admission	3.4 (2.8 -4.1)	2.2 (1.8 -2.8)
LDL-C in mmol/L at CR visit	1.9 (1.5 -2.4)	2.1 (1.6 -2.5)

Increase in statin therapy (low/medium intensity→ high intensity):
0.6 mmol/L LDL-C reduction

No change in statin therapy:
0.1 mmol/L LDL-C reduction





LDL-C reductions in patients on prior statin treatment are low, and treatment intensification in these patients is insufficient.

Schubert J et al. EHJ 2021

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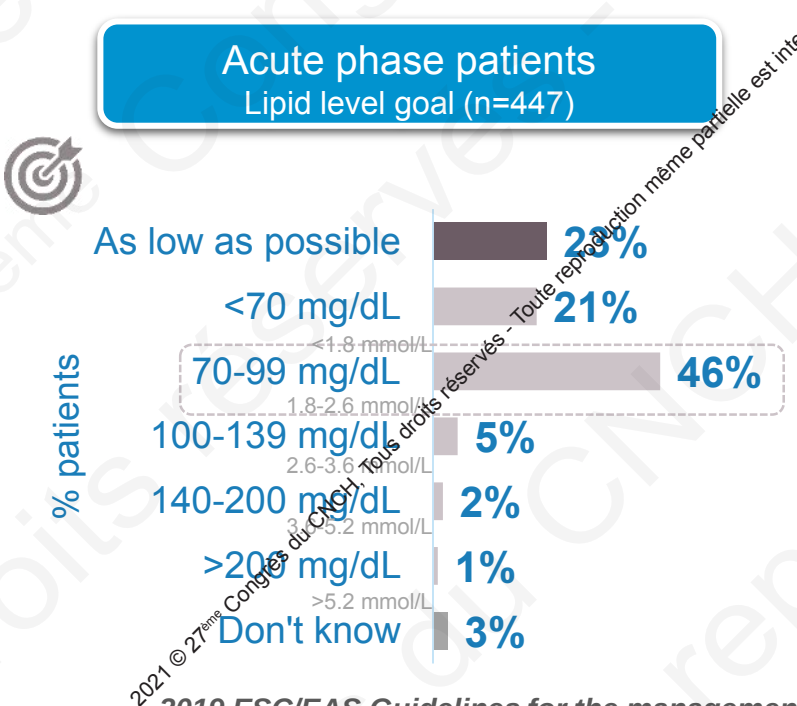
What is the LDL-C goal for this patient?



2019 ESC/EAS Guidelines for the management of dyslipidaemias

Des recommandations à la pratique clinique …

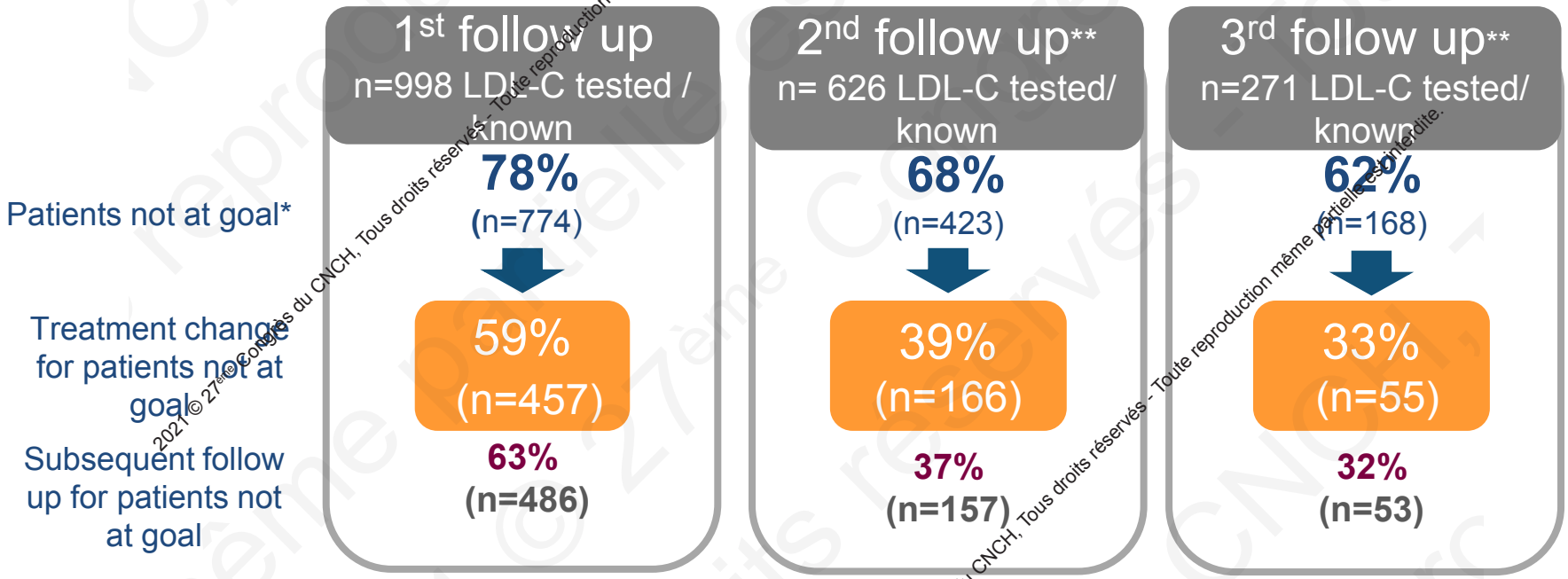
Autres constats à travers cette enquête :

- ✓ **Réalisation d'un bilan lipidique : 91 % (dosage LDL-C = 86%)**
- ✓ **Réadaptation cardio vasculaire planifiée à la sortie : 50%**
- ✓ **Screening FH : 18%**

Recommendations for the detection and treatment of patients with heterozygous familial hypercholesterolaemia	
FH is recommended to be suspected in patients with CHD before the age of 55 years for men and 60 years for women, in subjects with relatives with premature fatal or non-fatal CVD, in subjects with relatives having tendon xanthomas, and in subjects with severely elevated LDL-C [in adults >5 mmol/L (190 mg/dL), in children >4 mmol/L (150 mg/dL)].	I

2019 ESC/EAS Guidelines for the management of dyslipidaemias
Nordestgaard. Eur Heart J 2013

Constat : Peu de patients aux objectifs …



* LDL-C>70 mg/dL (>1.8 mmol/L) ** this data is looking at each follow up consultation independently

Suivi au cours de la première année : > 2/3 des patients ne sont pas aux objectifs et le traitement n'est pas optimal à la 3ème visite

Landmesser et al. Atherosclerosis 2020

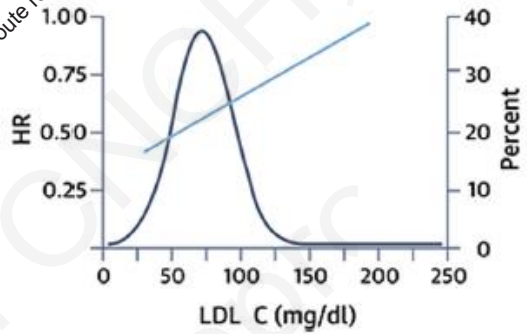
Constat : Peu de patients aux objectifs …

Very Low Levels of Atherogenic Lipoproteins and the Risk for Cardiovascular Events

A Meta-Analysis of Statin Trials

(38,153 patients; 8 essais randomisés entre 2009-2012)

- 18,677 patients traités à forte dose* de statines :
  - ✓ 13% avec un LDL-C > 100 mg/dl
  - ✓ 40% avec un LDL-C > 70 mg/dl
- Corrélation entre le taux de LDL et la survenue d'évènements cardiovasculaires majeurs

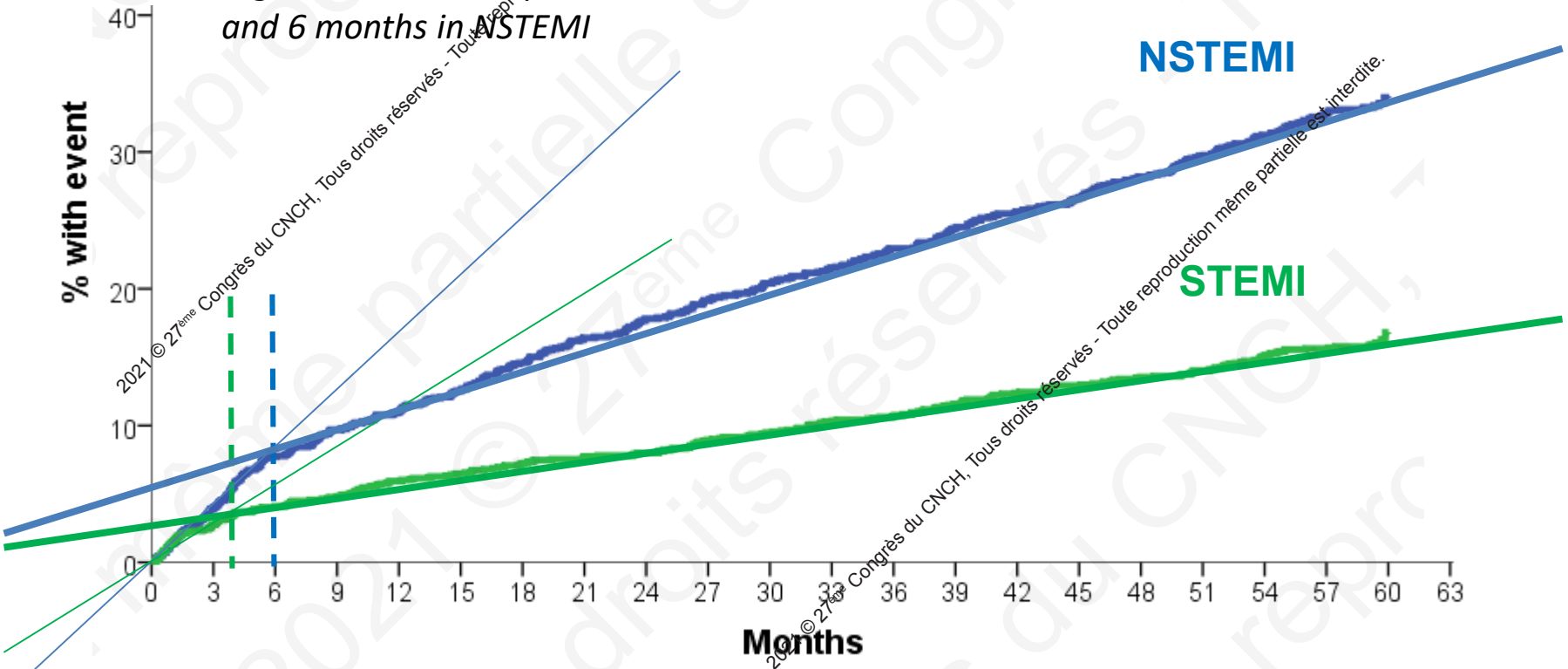


Boekholdt et al. JACC 2014

** Atorvastatine 80mg ou Rosuvastatine 20mg*

Décès à 5 ans après un infarctus. FAST-MI 2005

Higher event rates up to 3-4 months in STEMI and 6 months in NSTEMI



Puymirat E et al. ESC 2015

Syndrome Coronarien Aigu : Prise en charge de la dyslipidémie

SITUATION 1
Patients naïfs de statines

- ✓ Introduction de statines à fortes doses
- ✓ Education, règles hygiéno-diététiques

Niveau de recommandation : A

Réévaluation 1-3 mois

- ✓ Renforcement des règles hygiéno-diététiques
- ✓ ± Adaptation des doses de statines
- ✓ ± Ajout d'ezetimibe

Niveau de recommandation IIa-A

Patients avec LDL-C aux objectifs (LDL-C <0,55 g/L)	Patients avec LDL-C non aux objectifs (LDL-C ≥0,55 g/L)
	Inhibiteurs PCSK9 si LDL-C ≥ 0.70 g/L

SITUATION 2
Patients déjà sous statines

- ✓ Majoration des doses de statine
- ✓ ± Ajout d'ezetimibe

- ✓ Maintien de la dose de statine + ezetimibe
- ✓ Education, règles hygiéno-diététiques

Patients avec LDL-C aux objectifs (LDL-C <0,55 g/L)	Patients avec LDL-C non aux objectifs (LDL-C ≥0,55 g/L)
	Inhibiteurs PCSK9 si LDL-C ≥ 0.70 g/L

2019 ESC/EAS Guidelines for the management of dyslipidaemias. EHJ 2019

Proposition d'une lettre de sortie standardisée

Proposal for a standardized discharge letter after hospital stay for acute myocardial infarction

Francois Schiele ✉, Gilles Lemesle, Denis Angoulvant, Michel Krempf, Serge Kownator, Saida Cheggour, Loic Belle, Jean Ferrières, Christophe Bauters, MD, Cyrille Bergerot, MD, Farzin Beygui, MD, Franck Boccara, MD, Eric Bonnefoy, MD, Eric Bruckert, MD, Guillaume Cayla, MD, PhD, Jean-Philippe Collet, MD, Pierre Coste, MD, Vincent Descotes-Genon, MD, Gregory Ducrocq, MD, PhD, Meyer Elbaz, MD, Michel Farnier, MD, Emile Ferrari, MD, PhD, Dominique Guedj, MD, Laszlo Levai, MD, Jacques Mansourati, MD, Nicolas Mansencal, MD, PhD, Nicolas Meneveau, MD, PhD, Christophe Meune, MD, PhD, Olivier Morel, MD, Patrick Ohlmann, MD, Francois Paillard, MD, Christophe Piot, MD, Etienne Puymirat, MD, PhD, Gilles Rioufol, MD, PhD, François Roubille, MD, PhD, Pierre Sabouret, ME, Emmanuel Teiger, MD on behalf of the French Group

European Heart Journal
Acute Cardiovascular Care

Abstract

In patients admitted for acute myocardial infarction, the communication and transition from specialists to primary care physicians is often delayed, and the information imparted to subsequent healthcare providers (HCPs) may be sub-optimal. A French group of cardiologists, lipidologists and diabetologists decided to establish a consensus to optimize the discharge letter after hospitalization for acute myocardial infarction. The aim is to improve both the timeframe and the quality of the content transmitted to subsequent HCPs, including information regarding baseline assessment, procedures during hospitalization, residual risk, discharge treatments, therapeutic targets and follow-up recommendations in compliance with European Society of Cardiology guidelines. A consensus was obtained regarding a template discharge letter, to be released within two days after patient's discharge, and containing the description of the patient's history, risk factors, acute management, risk assessment, discharge treatments and follow-up pathway. Specifically for post-acute MI patients, tailored details are necessary regarding the antithrombotic regimen, lipid-lowering and anti-diabetic treatments, including therapeutic targets. Lastly, the follow-up pathway needs to be precisely mentioned in the discharge letter. Additional information such as technical descriptions, imaging, and quality indicators may be provided separately. A template for a standardized discharge letter based on 8 major headings could be useful for implementation in routine practice and help to improve the quality and timing of information transmission between HCPs after acute MI.

Schiele et al. Eur Heart J Acute Cardiovasc Care 2020

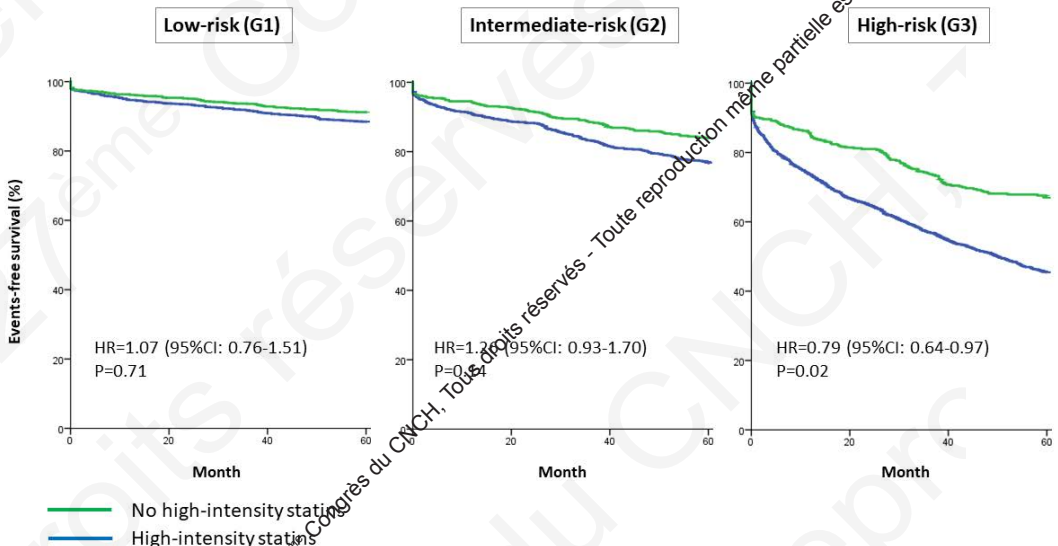
Pronostic à long terme selon le traitement initial

FAST MI 2005 et 2010

Survie à 5 ans selon la dose statine prescrite à la sortie et selon la gravité du patient (TRS2P)

TRS 2°P Risk Indicators	Points
CHF	1
HTN	1
Age ≥75	1
DM	1
Prior Stroke	1
Prior CABG	1
PAD	1
eGFR <60	1
Smoking	1
Maximum Possible	9

TRS-2P	Risk-categories
0-1	Low-risk
2	Intermediate-risk
≥3	High-risk



Desjobert E et al. ACVD 2021

Conclusions

Constats de la prise en charge du patient post-SCA dès l'USIC :

- Discordance entre les recommandations et la pratique clinique
- Risque résiduel est maximum au décours du SCA
- Optimiser la prise en charge initiale en favorisant les associations d'hypolipémiants
- La prise en charge initiale est capitale pour le suivi

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