Le prétraitement dans le syndrome coronaire aigu

MA BOUZID, Alger

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DÉCLARATION DE LIENS D'INTÉRÊT AVEC LA PRÉSENTATION

Nom de l'orateur : Mohammed El Amine BOUZID, Alger

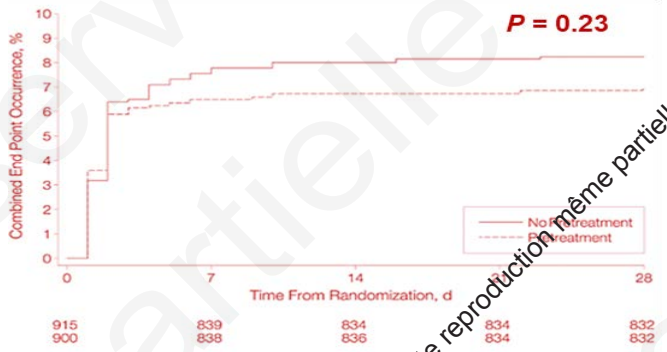
☑ Je n'ai pas de lien d'intérêt potentiel à déclarer

Prétraitement

- Initiation des inhibiteurs des recepteurs P2Y12, soit en pré-hospitalier, aux pavillons des urgences/USIC/ au cath-lab avant de connaitre l'anatomie coronaire au décours d'un SCA

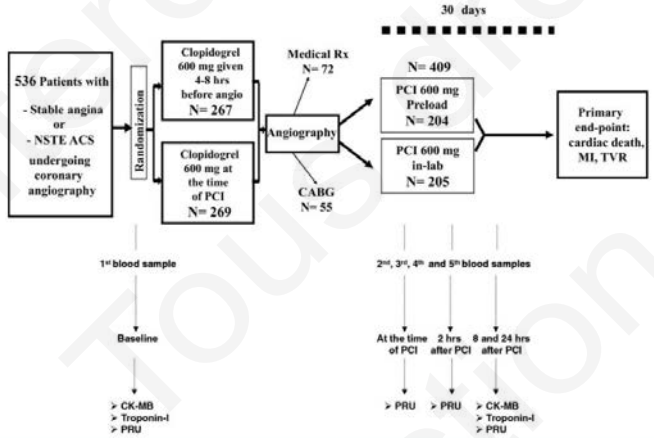
- La dose de charge d'un puissant inhibiteur du récepteur $P2Y_{12}$, avant la coronarographie, réduira le risque de complications thrombotiques lors d'une PCI. Ceci est d'autant plus important chez les patients souffrant d'un SCA, chez qui les plaquettes sont déjà fort activées (plusieurs études CURE, PCA-CURE, CLARITY …)

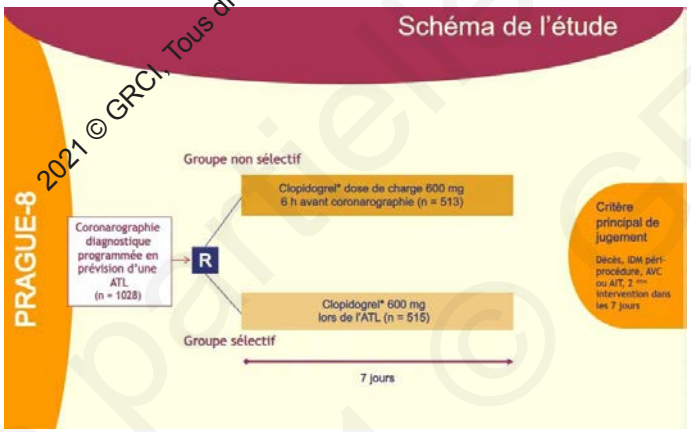
CREDO

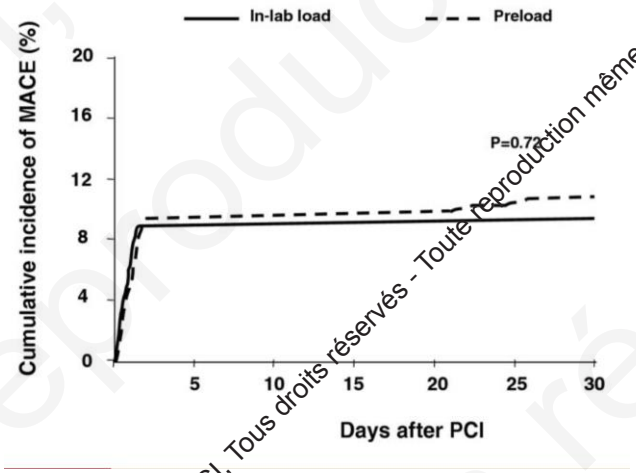


Steinhubl S et al. JAMA. 2008;288(19):2411-2420

ARMYDA-5 Preload







Widimski P et al.2008;29:1495-503

Di Sciascio G et al.JAAC 2010;10;56:550-7

Avant l'étude ACCOAST, le prétraitement était la règle

Class 1	?
2005	2013
Clopidogrel	New P2Y12 blockers
Delayed action (12-24h)	Fast acting drug (<1h)
Invasive strategy: rare and late	Invasive strategy: frequent and early

ACCOAST (Prasugrel)

Pretreatment with Prasugrel in Non–ST-Segment Elevation Acute Coronary Syndromes

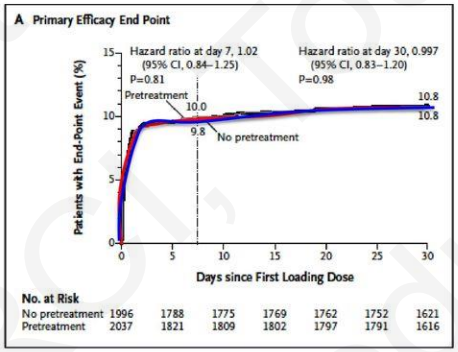
ACCOAST STUDY — Montalescot and al, NEJM 2013

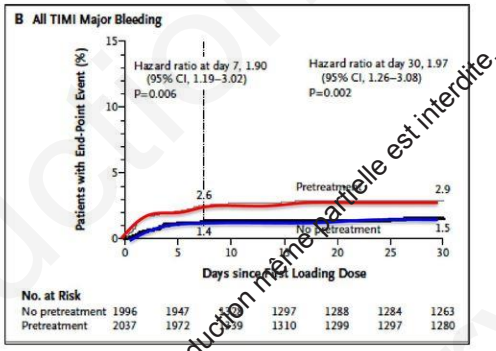
4033 patients admis pour un NSTEMI

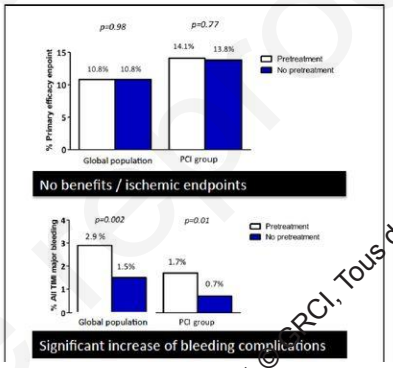
TRT med Ou CABG STOP prasugrel	Prétraitement avec PRASUGREL 30 mg puis PRASUGREL 30mg après angioplastie	Prétraitement avec placebo puis PRASUGREL 60mg après angioplastie	TRT med Ou CABG STOP prasugrel

PRASUGREL 5 ou 10 mg en fonction de l'âge

Composite end point: Mortalité cardiovasculaire, infarctus , AVC, revascularisation urgente à J7



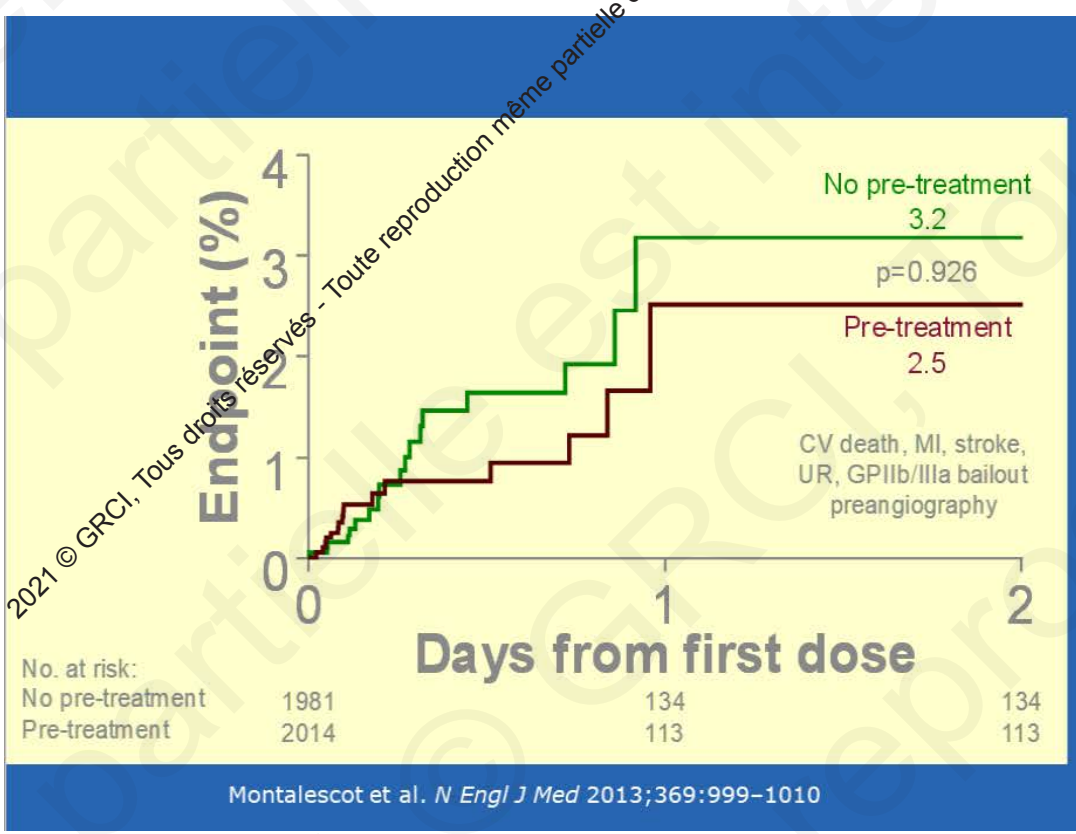


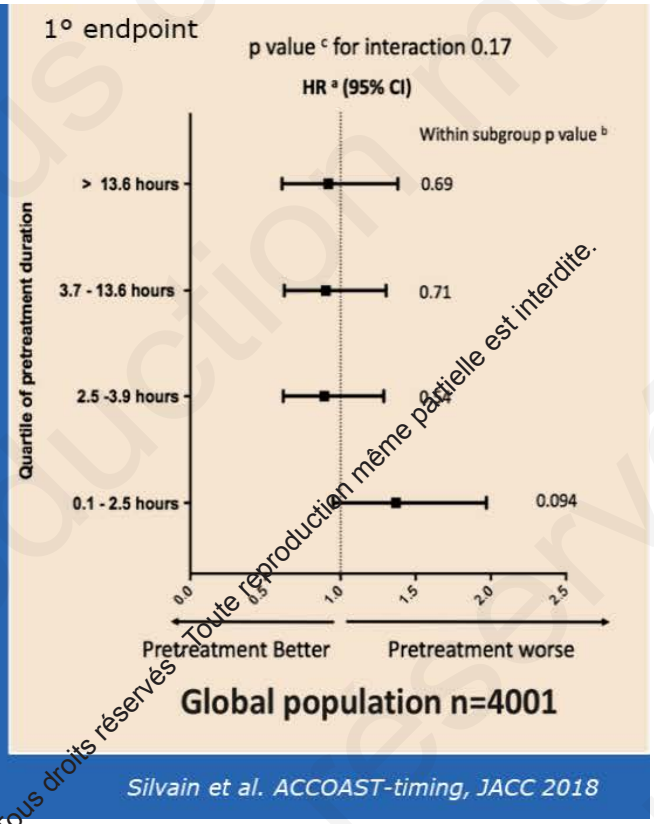


CONCLUSION ACCOAST

- Pas de bénéfice du pré-traitement par PRASUGREL
- PAS DE bénéfice dans le groupe PCI
- Augmentation des complications hémorragiques

ACCOAST (Prasugrel)





Pas de sur-risque en attente de la coronarographie

DUBIUS (Ticagrelor)

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Downstream or Upstream P2Y12 Receptor Blockers in NSTE-ACS: Primary Results of the DUBIUS Trial

Mar 15, 2021 | Giuseppe Tarantini; Marco Mojoli, MD

Expert Analysis

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Quick Takes

- The available evidence related to the clinical impact of pretreatment has been incomplete and heterogeneous regarding the different P2Y12 inhibitors.
- In the DUBIUS (Downstream Versus Upstream Strategy for the Administration of P2Y12 Receptor Blockers in Non-ST Elevated Acute Coronary Syndromes With Initial Invasive Indication) trial, downstream and upstream oral P2Y12 inhibitor administration strategies were associated with low incidence of ischemic and bleeding events and minimal numeric difference of event rates between treatment groups.
- Broad use of a radial approach may have contributed to the low observed adverse event rates.

Related Content

Downstream versus Upstream administration of P2Y12 receptor Blockers In non-ST elevated acUte coronary Syndromes with initial invasive indication

The Clopidogrel in Unstable Angina to Prevent Recurrent Events Trial Investigators: Effects of Clopidogrel in Addition to Aspirin in Patients With Acute Coronary Syndromes Without ST-Segment Elevation

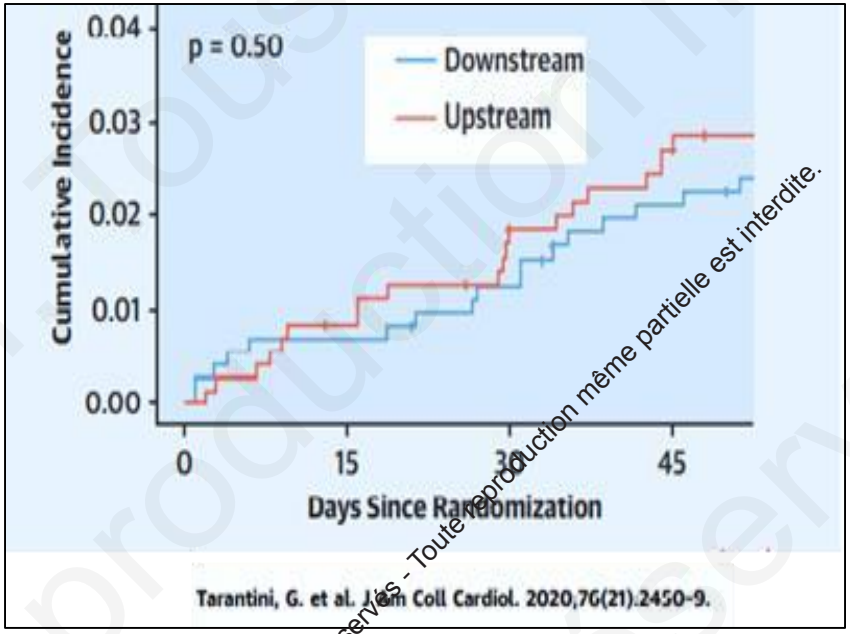
Clopidogrel for Reduction of Events During Observation

PLATelet inhibition and patient Outcomes

Trial to Assess Improvement in Therapeutic Outcomes by Optimizing Platelet Inhibition With Prasugrel–Thrombolysis In Myocardial Infarction 38

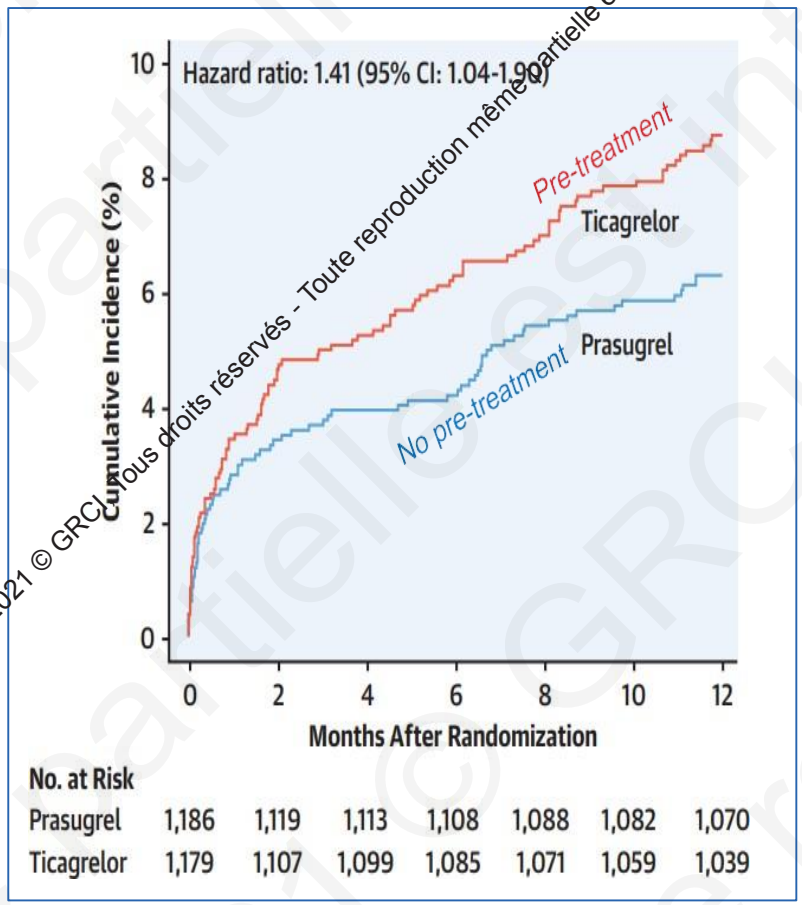
Comparison of Prasugrel at the Time of PCI or as Pretreatment at the Time of Diagnosis in Patients With Non-ST Elevation Myocardial Infarction

Intracoronary Stenting and Antithrombotic Regimen 5

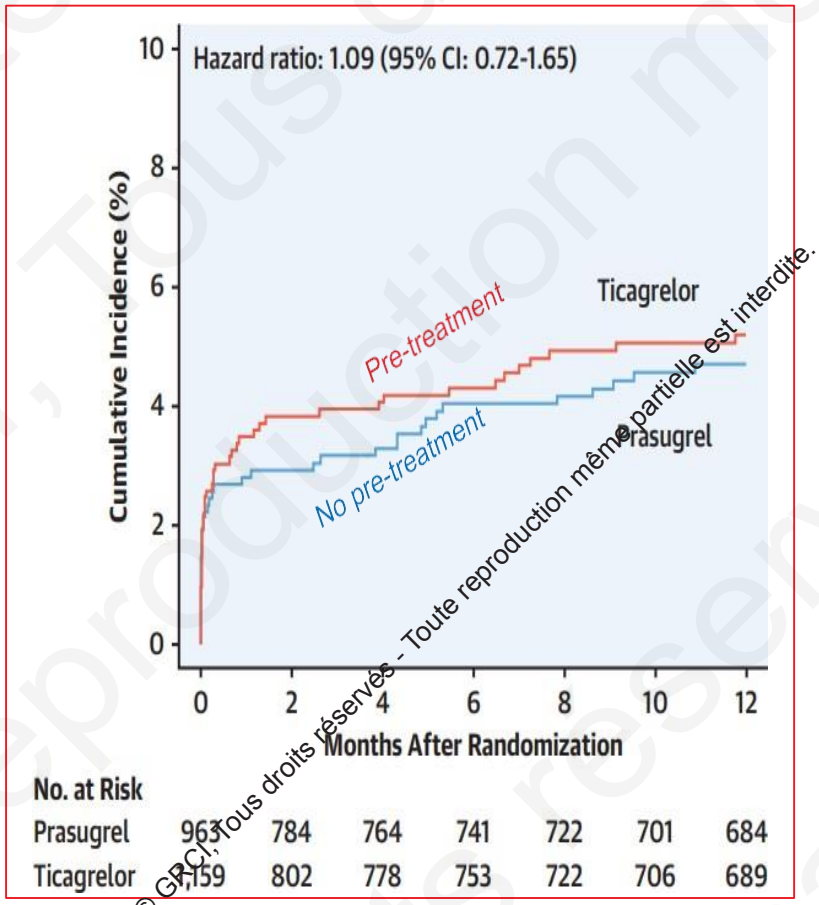


ISAR REACT 5 - NSTE-ACS

1°EP: death, MI, Stroke



Safety EP: BARC 3-5



Valina C et al. J Am Coll Cardiol 2020;76:2436–46

ESC European Society of Cardiology
European Heart Journal (2021) 42, 1289–1367
doi:10.1093/eurheartj/ehaa575

ESC GUIDELINES

2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

The Task Force for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation of the European Society of Cardiology (ESC)

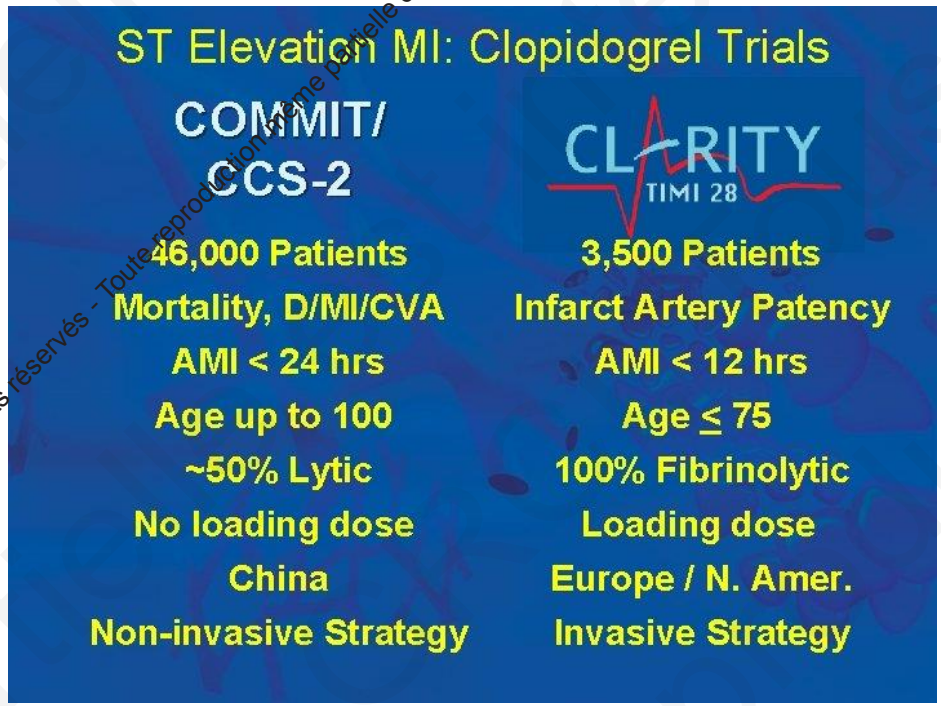
Authors/Task Force Members: Jean-Philippe Collet * (Chairperson) (France), Holger Thiele * (Chairperson) (Germany), Emanuele Barbato (Italy), Olivier Barthélémy (France), Johann Bauersachs (Germany), Deepak L. Bhatt (United States of America), Paul Cendale (Belgium), Maria Dorobantu (Romania), Thor Edvardsen (Norway), Thierry Folliguet (France), Chris P. Gale (United Kingdom), Martine Gilard (France), Alexander Jobs (Germany), Peter Jüni (Canada), Ekaterini Lambrinou (Cyprus), Basil S. Lewis (Israel), Julinda Mehilli (Germany), Emanuele Meliga (Italy), Béla Merkely (Hungary), Christian Mueller (Switzerland), Marco Roffi (Switzerland), Frans H. Rutten (Netherlands), Dirk Sibbing (Germany), George C.M. Siontis (Switzerland)

Treatment with GP IIb/IIIa antagonists in patients in whom coronary anatomy is not known is not recommended.[188,189]	III	A
It is not recommended to administer routine pre-treatment with a $P2Y_{12}$ receptor inhibitor in patients in whom coronary anatomy is not known and an early invasive management is planned.[174,177,178,190,191]	III	A

Messages clés (NSTEMI)

- Il **n'est pas recommandé** de prétraiter **de routine** par un inhibiteur du récepteur P2Y12 chez les patients dont **l'anatomie coronaire n'est pas connue** et pour lesquels une prise en charge invasive **précoce** est prévue (classe III A)
- Patients NSTEMI qui ne peuvent pas bénéficier d'une stratégie invasive précoce, un préTRT peut être envisagé chez les patients à faible risque hémorragique (classe II b) >>>> **prise en charge individualisée**
- Le Prasugrel doit être préféré au Ticagrelor chez les patients atteints de NSTE-ACS qui vont bénéficier d'angioplastie (classe IIa b)

STEMI

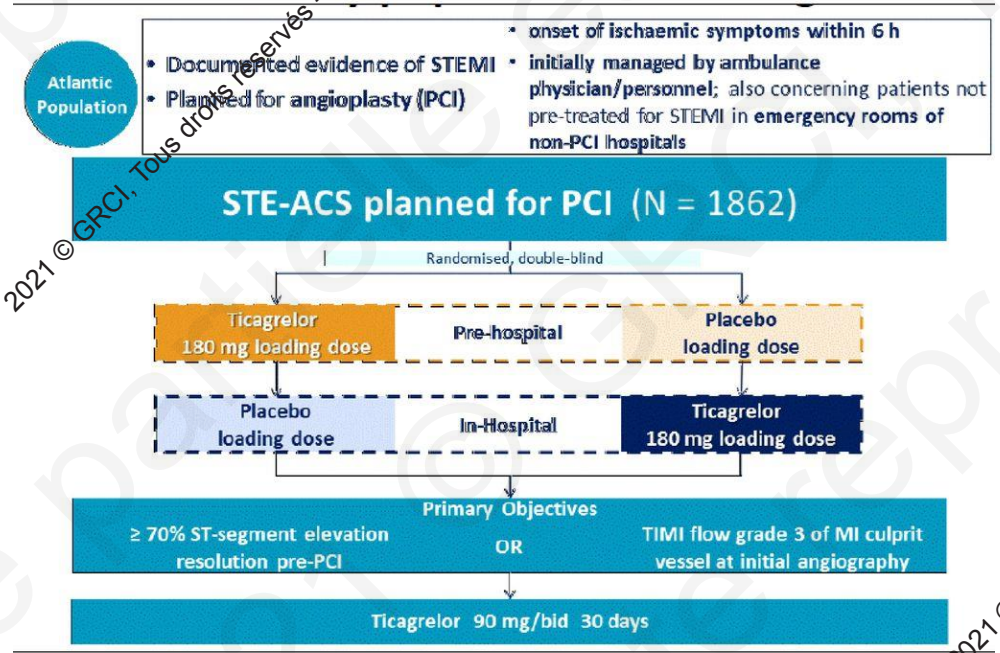


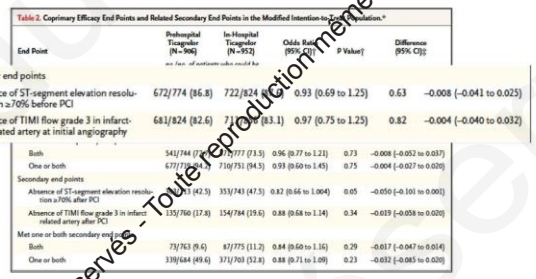
Ces 2 études ont validé (bien qu'imparfaitement) l'utilité d'un traitement d'emblée par aspirine et clopidogrel dans le STEMI, qu'il y ait ou non angioplastie primaire

STEMI

ATLANTIC

Administration of **T**icagrelor in the cath **L**ab or in the **A**mbulance for **N**ew ST elevation myocardial **I**nfarction to open the **C**oronary artery





Recommendations	Class[b]	Level[c]
Antiplatelet therapy		
A potent $P2Y_{12}$ inhibitor (prasugrel or ticagrelor), or clopidogrel if these are not available or are contraindicated, is recommended before (or at latest at the time of) PCI and maintained over 12 months, unless there are contraindications such as excessive risk of bleeding.[186,187]	I	A
Aspirin (oral or i.v. if unable to swallow) is recommended as soon as possible for all patients without contraindications.[213,214]	I	B
GP IIb/IIIa inhibitors should be considered for bailout if there is evidence of no-reflow or a thrombotic complication.	IIa	C
Cangrelor may be considered in patients who have not received $P2Y_{12}$ receptor inhibitors.[192–194]	IIb	A

ESC European Society of Cardiology
European Heart Journal (2017) 0, 1–48
doi:10.1093/eurheartj/ehx419

ESC GUIDELINES

2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS

The Task Force for dual antiplatelet therapy in coronary artery disease of the European Society of Cardiology (ESC) and of the European Association for Cardio-Thoracic Surgery (EACTS)

Seulement en bail-out, plus en systématique en cas de forte charge thrombotique

A Considérer

Conclusion

- Aspirine (dose de charge) doit être administrée dés le diagnostic de SCA (NSTEMI et STEMI)
- **NSTEMI :** pas de préTRT par des inhibiteurs P2Y12 avant de connaitre les lésion coronaires **en cas de stratégie invasive précoce**
- Patients **NSTEMI** qui ne peuvent pas bénéficier d'une stratégie invasive précoce, un préTRT peut être envisagé chez les patients à faible risque hémorragique (classe IIb)>>>> **prise en charge individualisée**
- **STEMI:** dose de charge de Prasugrel ou Ticagrelor/Clopidogrel dés le diagnostic