ANGINA INSTABILE ED NSTEMI: UNA PATOLOGIA CORONARICA "MINORE"?

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CONCLUSIONI
NO!

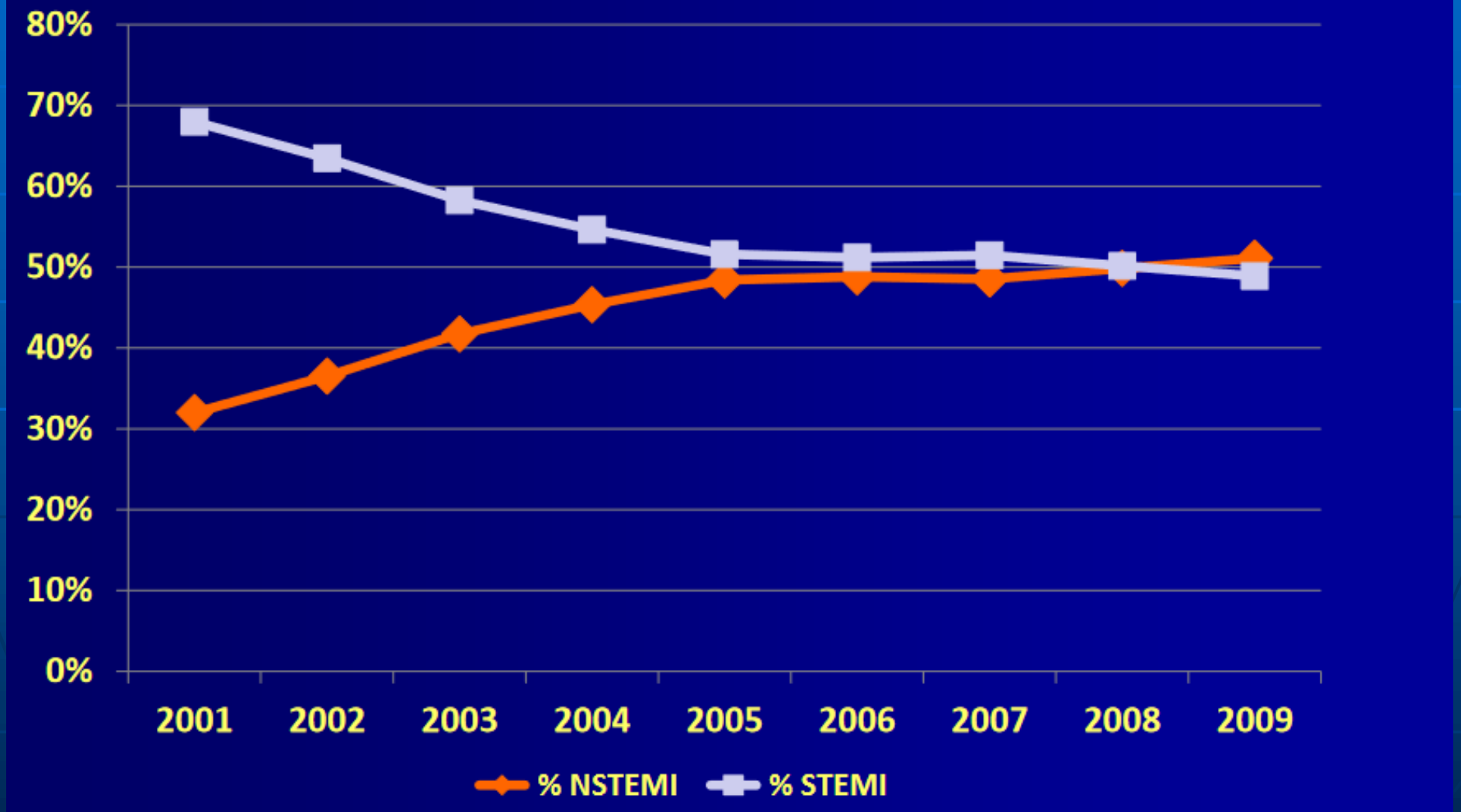
NSTEMI

- EPIDEMOLOGIA
- PROGNOSI
- PECULIARITA' TERAPEUTICHE

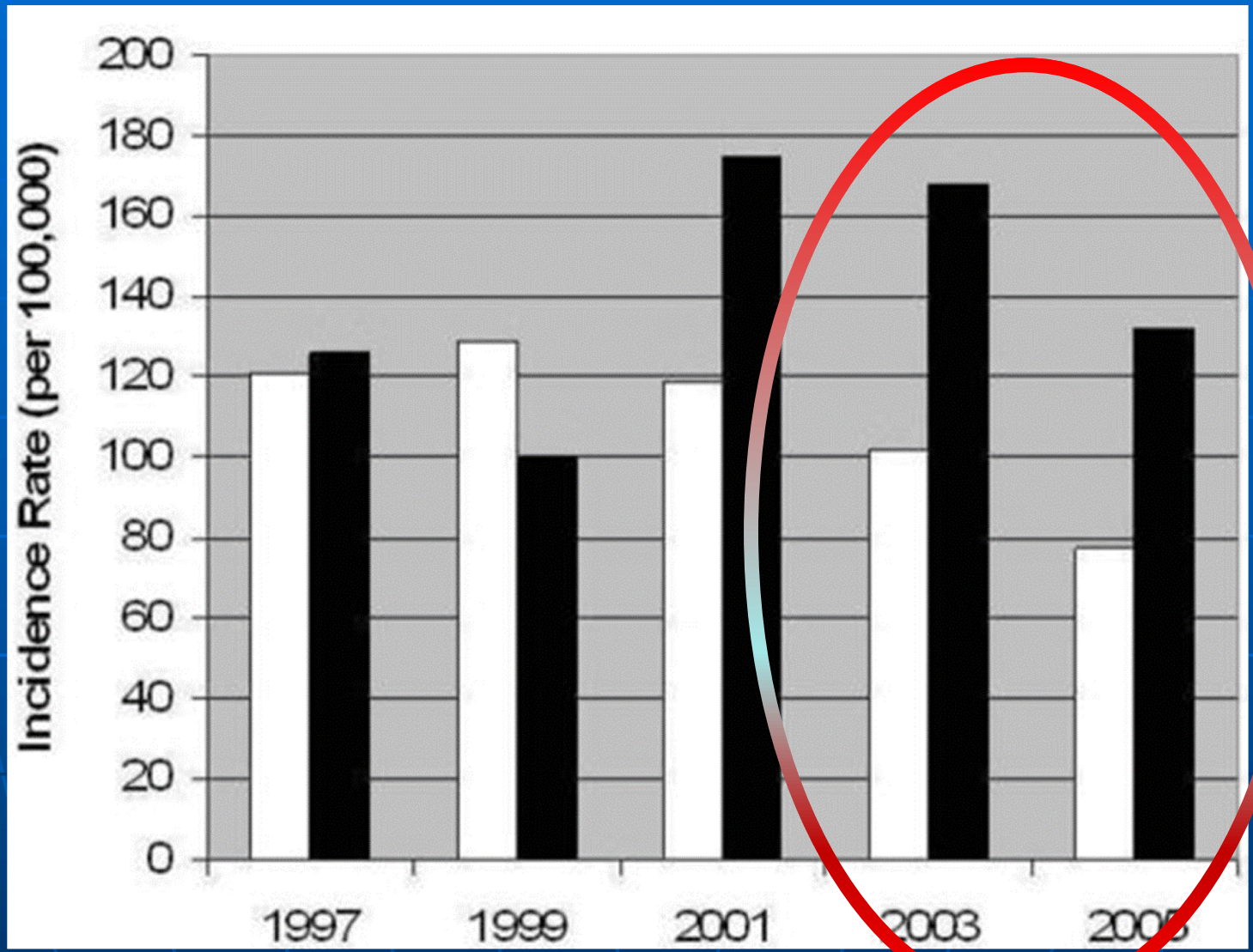
NSTEMI

- **EPIDEMOLOGIA**
- **PROGNOSI**
- **PECULIARITA' TERAPEUTICHE**

SDO nazionali 2001-2009
Proporzione di IMA STEMI e NSTEMI



Incidence Rates for STEMI and NSTEMI by Study Year



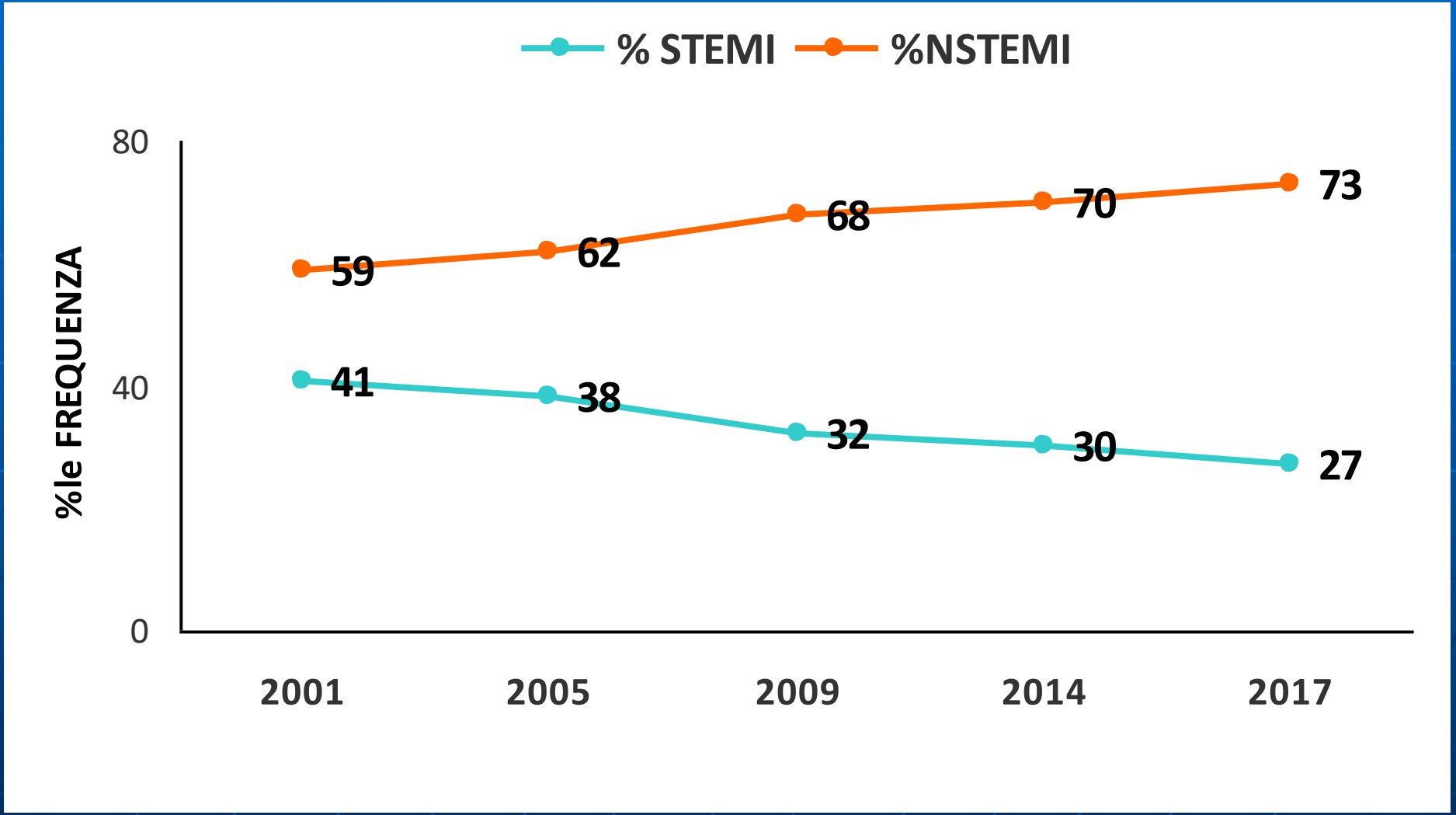
McManus DD et al. Am J Med 2011

2008 - 2010

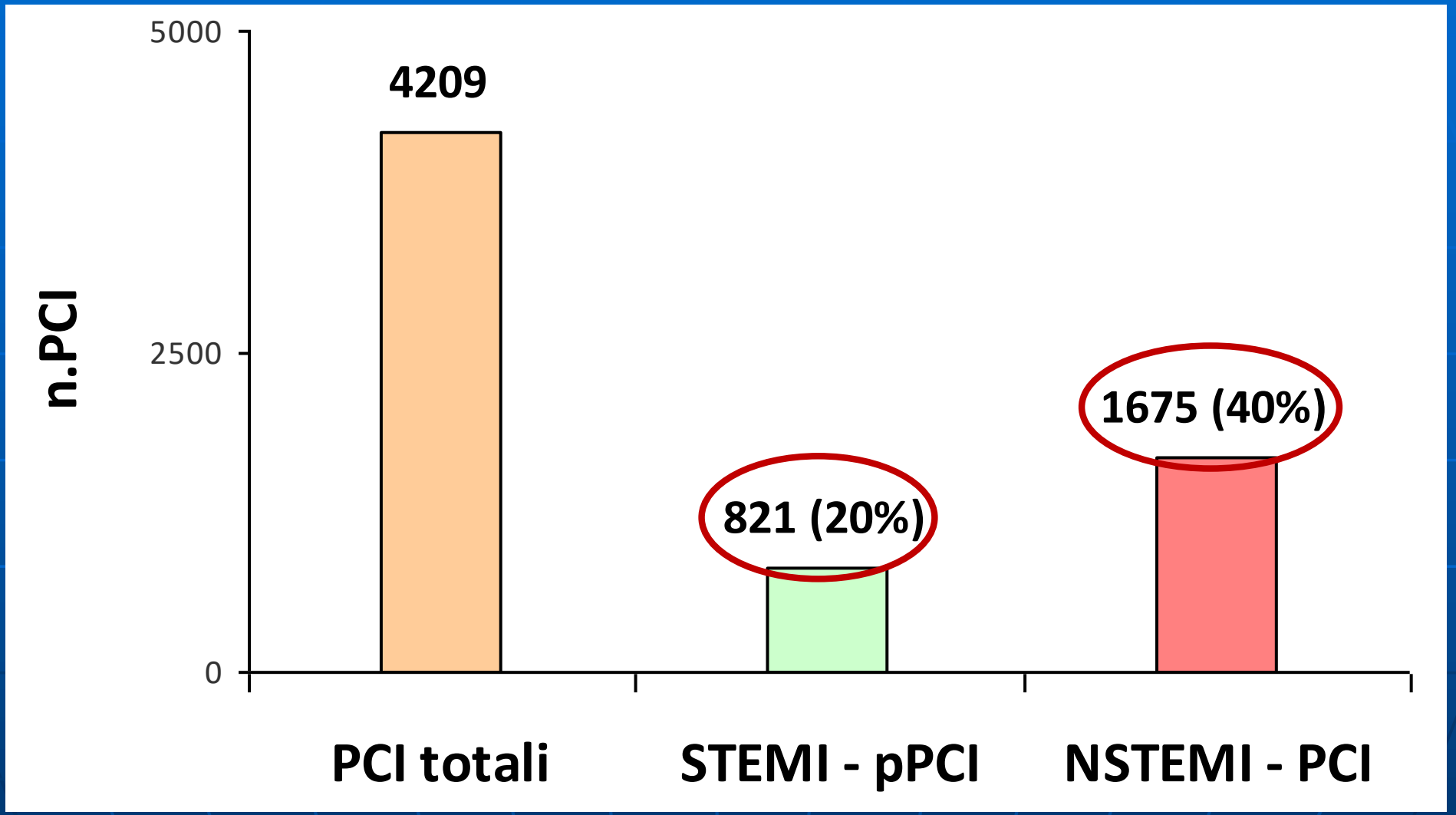
Frequenza STEMI e NSTEMI nei dati AMI-Florence 2 e nei dati SDO

Studio AMI Florence 2				Diagnosi principale SDO[$]		
	N°	%			N°	%
STEMI	1.108	34,5%		<> 410.7	1.522	54,9%
NSTEMI	2.105	74,5%		410.7	1.251	45,1%
Totale	3.213	100%		Totale	2.773	100%

CARDIOLOGIA PRATO - %le SCA

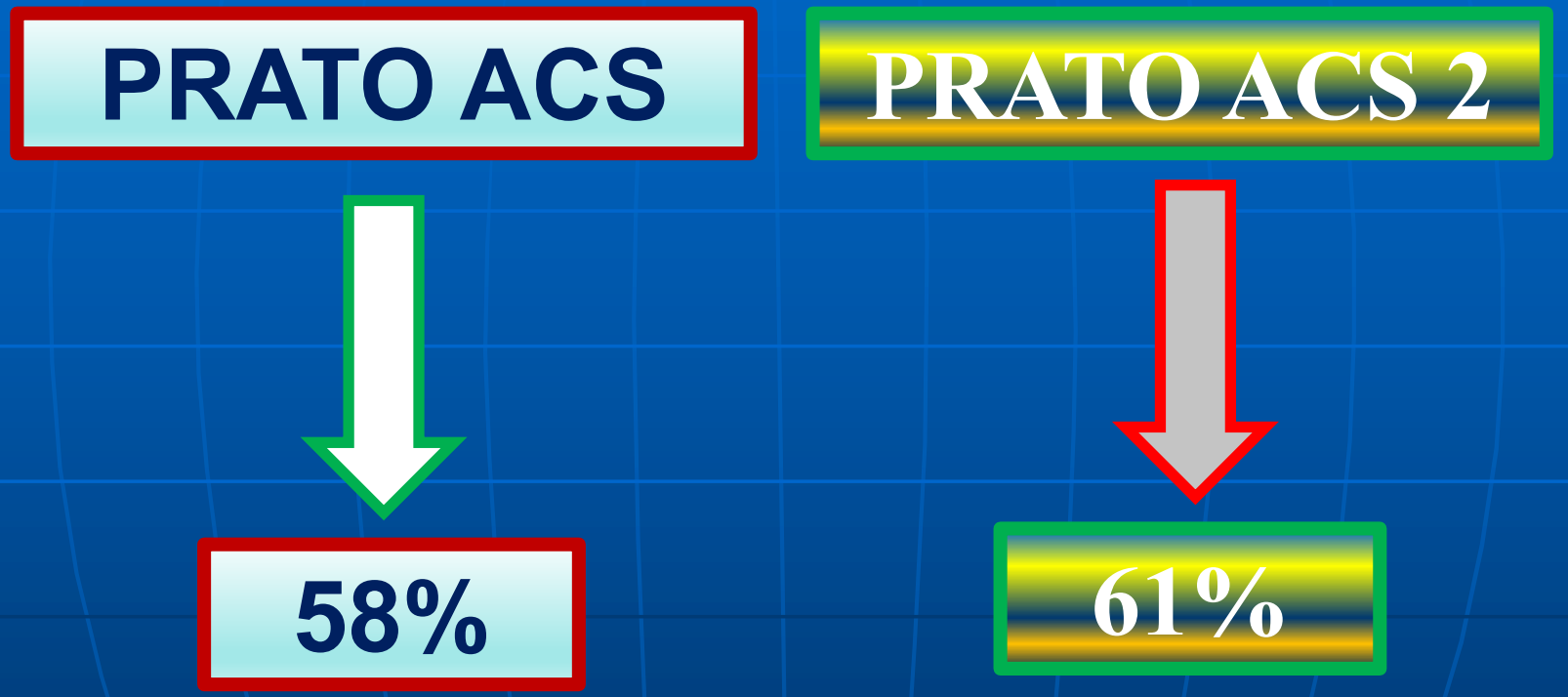


AREA VASTA CENTRO – n.PCI – 2016



LABORATORI AZIENDA USL TOSCANA CENTRO

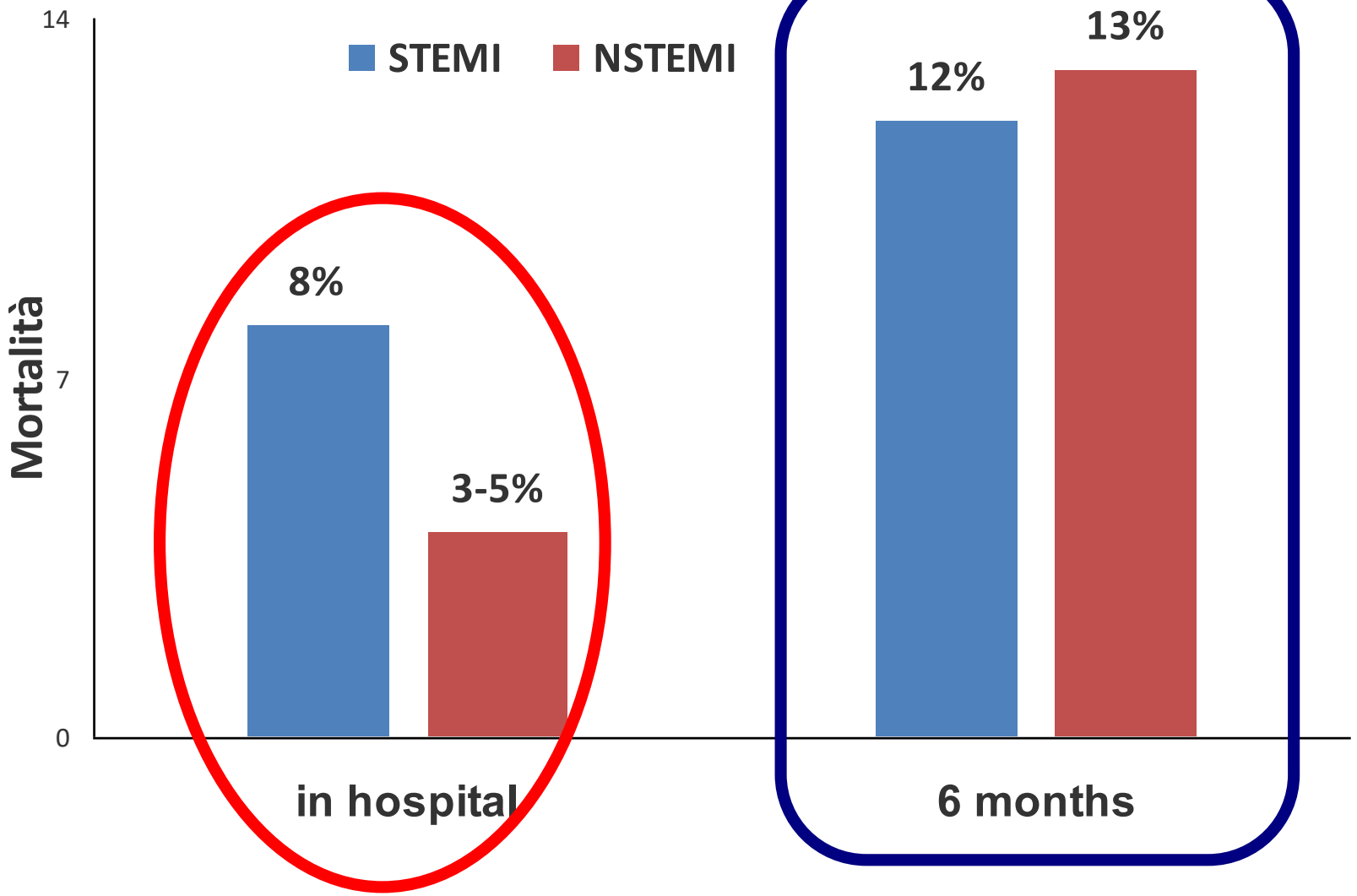
%le di RIVASCOLARIZZAIONE PERCUTANEA IN CORSO DI NSTEMI



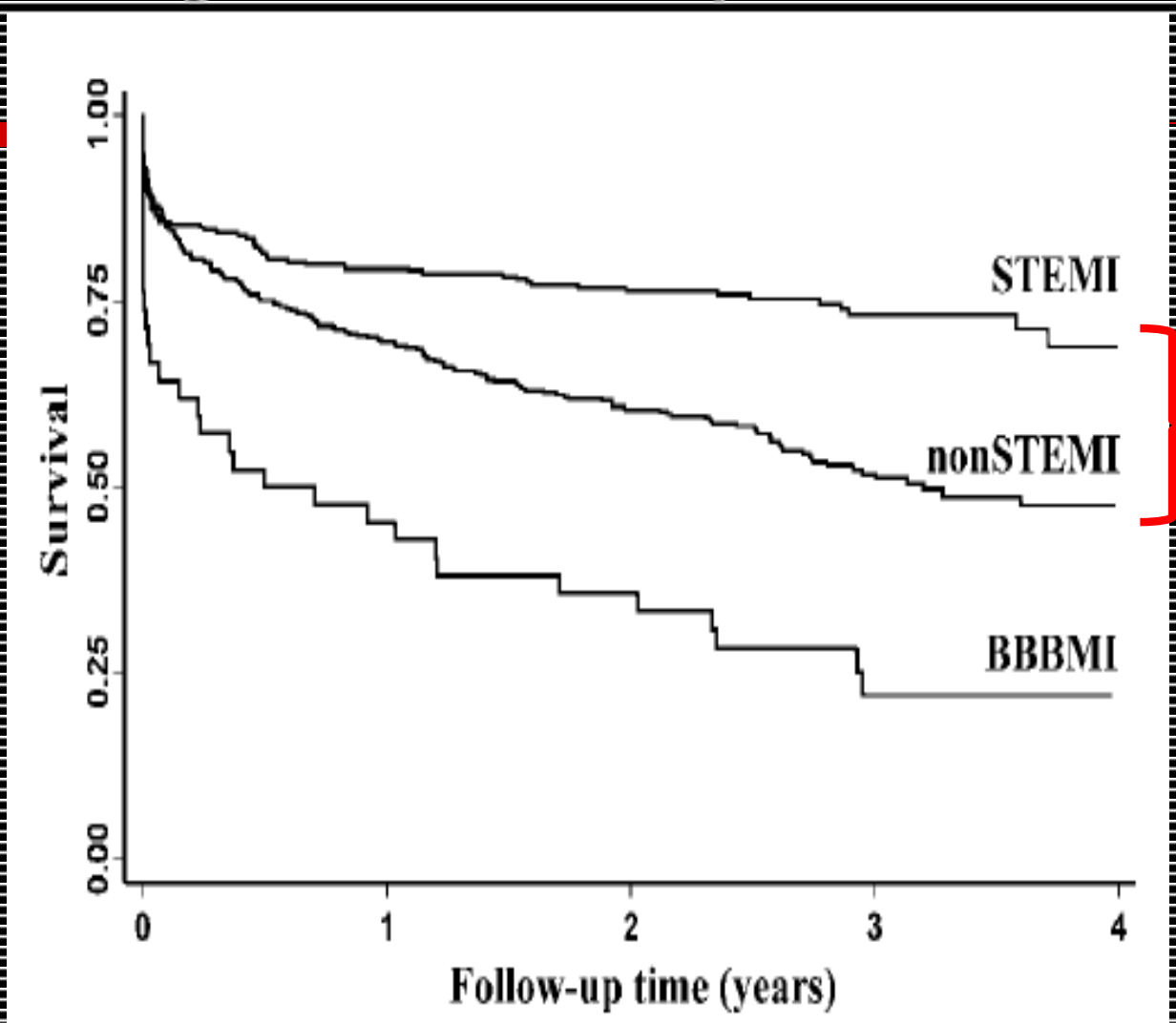
Toso A et al. JACC 2014; ACC 2017

NSTEMI

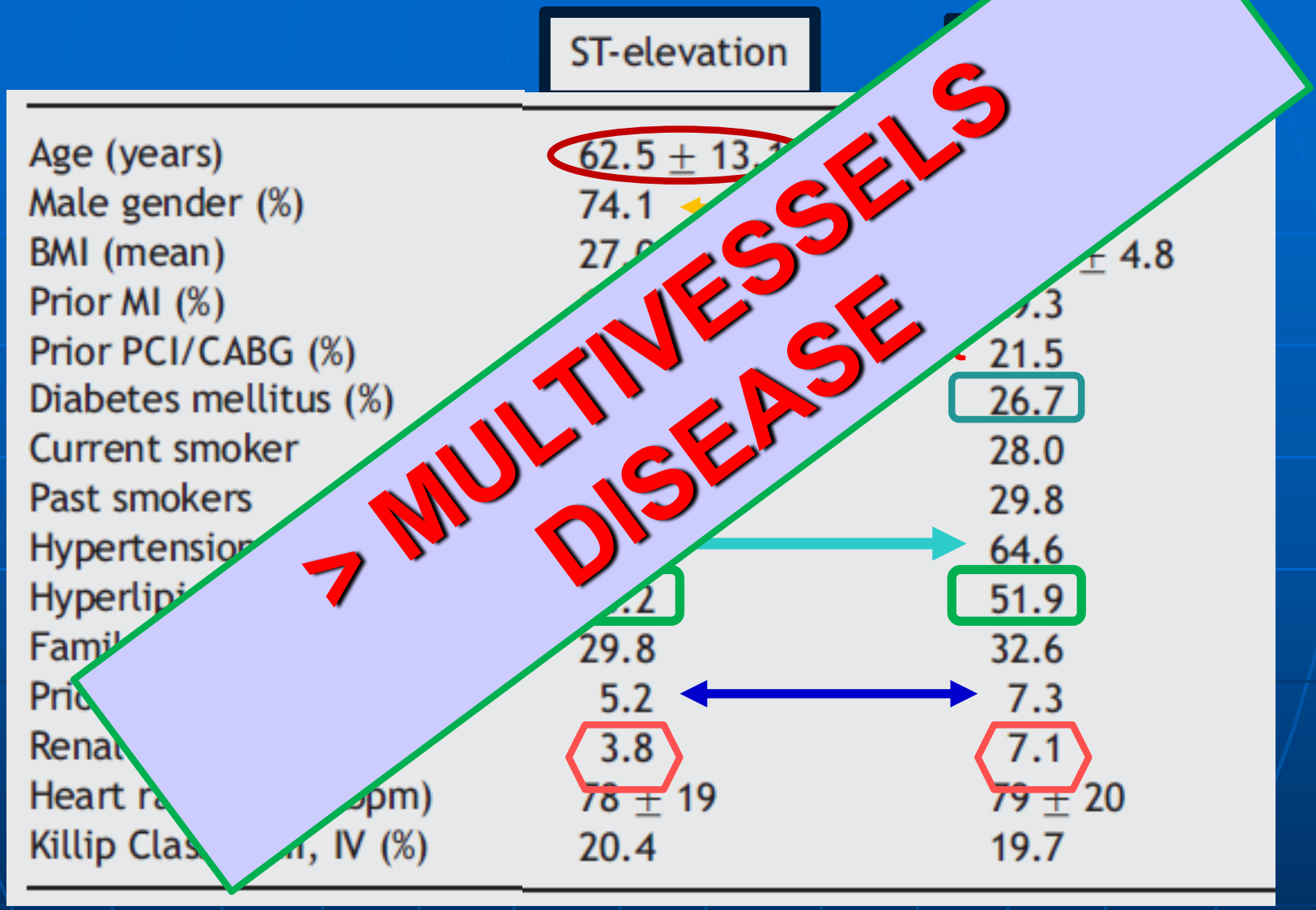
- EPIDEMOLOGIA
- PROGNOSI
- PECULIARITA' TERAPEUTICHE


14
7
0
Mortalità
STEMI
NSTEMI
8%
3-5%
12%
13%
in hospital
6 months

Unadjusted Kaplan–Meier survival curves for different categories of acute myocardial infarction



BASELINE, DEMOGRAPHIC, AND CLINICAL CHARACTERISTICS



Euro Heart Survey 2006

NSTEMI

- EPIDEMOLOGIA
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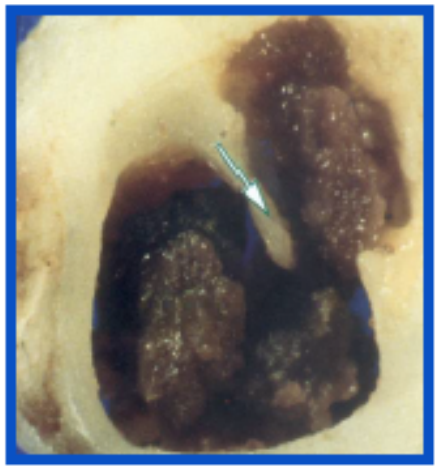
NSTEMI

PECULIARITA' TERAPEUTICHE

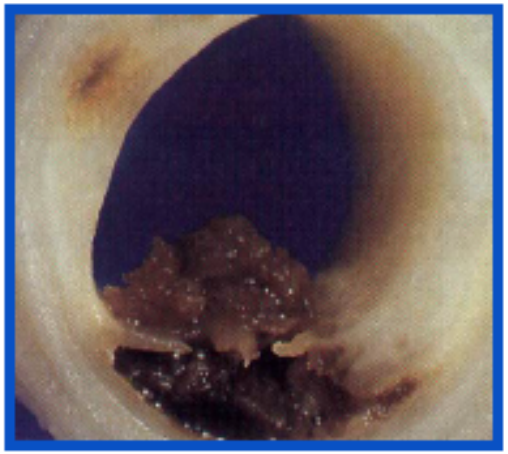
- **PRETRATTAMENTO**
- RIVASCOLARIZZAZIONE

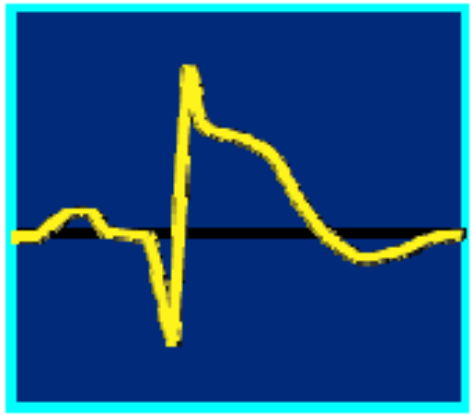
Pathophysiology

ACS with persistent ST-segment elevation



ACS without persistent ST-segment elevation

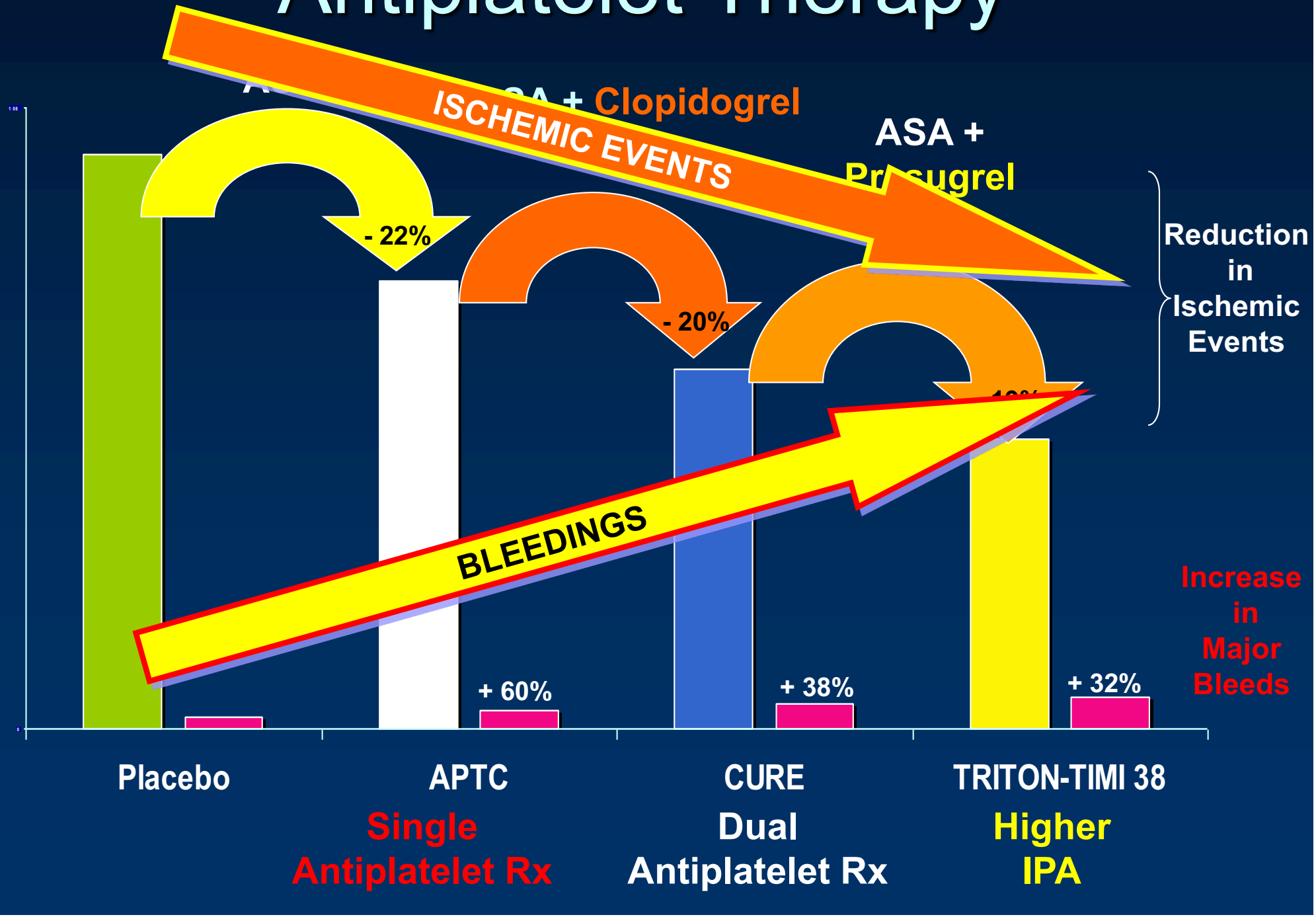




CARATTERISTICHE FARMACOCINETICHE E FARMACODINAMICHE DEGLI INIBITORI ORALI DEL RECETTORE PIASTRINICO P2Y12

	Clopidogrel	Prasugrel	Ticagrelor
Via di somministrazione	Orale	Orale	Orale
Dosaggio	300-600 mg carico poi 75 mg/die	60 mg carico poi 10 mg/die	180 mg carico poi 90 mg bid
Dosaggio per eGFR <15 ml/min/1.73 m^2	Usare solo in caso di indicazioni particolari (es. prevenzione della trombosi di stent)	Non raccomandato	Non raccomandato
Legame al recettore	Irreversibile	Irreversibile	Reversibile
Attivazione[a]	Profarmaco con un metabolismo epatico variabile[b]	Profarmaco con un metabolismo epatico prevedibile[b]	Farmaco con un metabolita attivo addizionale[b]
Cinetica di inibizione dell'aggregazione piastrinica	23% ad 1h 40-60% a 4-6h dopo carico di 600 mg	80% ad 1h	79% ad 1h 93% a 2.2h
Comparsa dell'effetto dopo dose di carico	2-6h	30 min	30 min
Durata dell'effetto	3-10 giorni	7-10 giorni	3-5 giorni
Emivita della forma attiva	30-60 min	30-60 min	6-12h
Inibizione del reuptake dell'adenosina	No	No	Sì

Antiplatelet Therapy




yes
no
PRETREATMENT

PRETREATMENT

NSTEMI DIAGNOSIS

PRETREATMENT IS [illegible]ED AS ANY TREATMEN[illegible] BEFORE THE CORO[illegible]ATOMY HAS BEEN [illegible]AND A DECISION ABOUT RE[illegible]ULARIZATION IS UNDERTAKEN

UPSTREAM P2Y12 LOADING (PRETREATMENT)

Potential advantages

- More ischemic protection while waiting for coronary angiography
- More time for the drug to achieve full antiplatelet effects
- Less acute stent thrombosis
- Less need for bailout glycoprotein IIIb/IIIa inhibitors

UPSTREAM P2Y12 LOADING (PRETREATMENT)

Potential disadvantages

- Useless for patients who ultimately show no coronary artery disease
- Increased bleeding
- Harmful for patients who need immediate coronary artery bypass grafting
- Increased cost due to prolonged hospitalization if surgical revascularization required

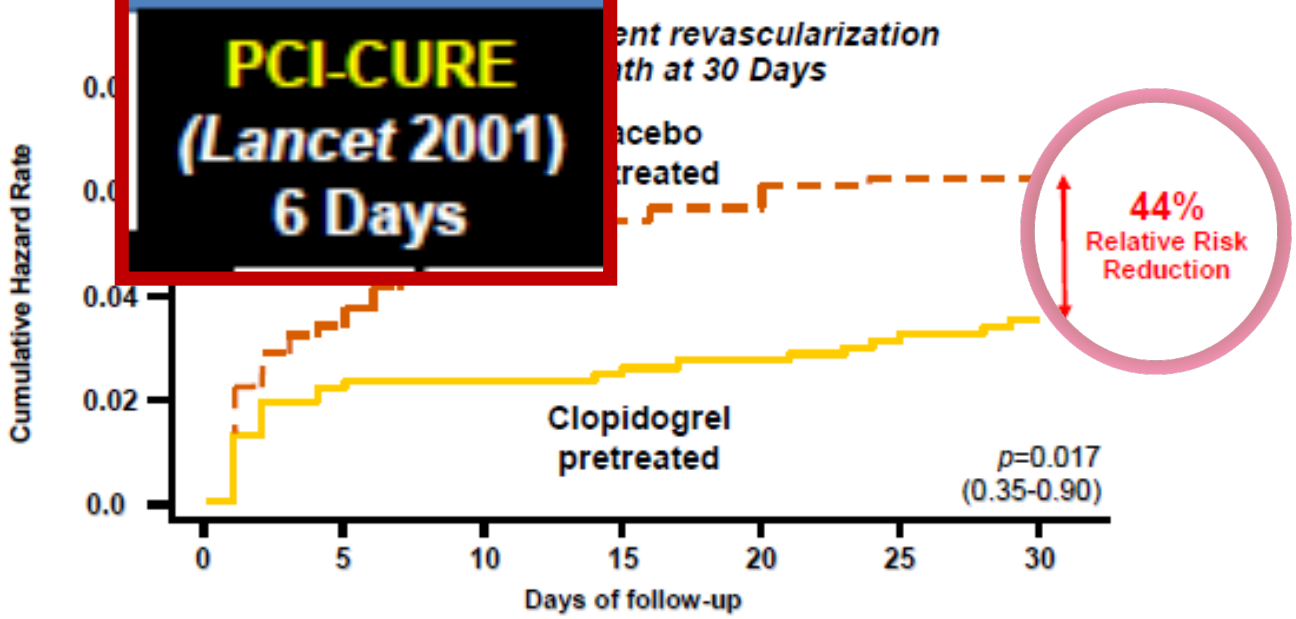
Pre-Treatment with Clopidogrel Prior to PCI and Stenting in ACS Patients

Placebo | Clopidogrel | Placebo

PCI | 30 days | 1 year

Time to Cath Lab | pidogrel | Clopidogrel

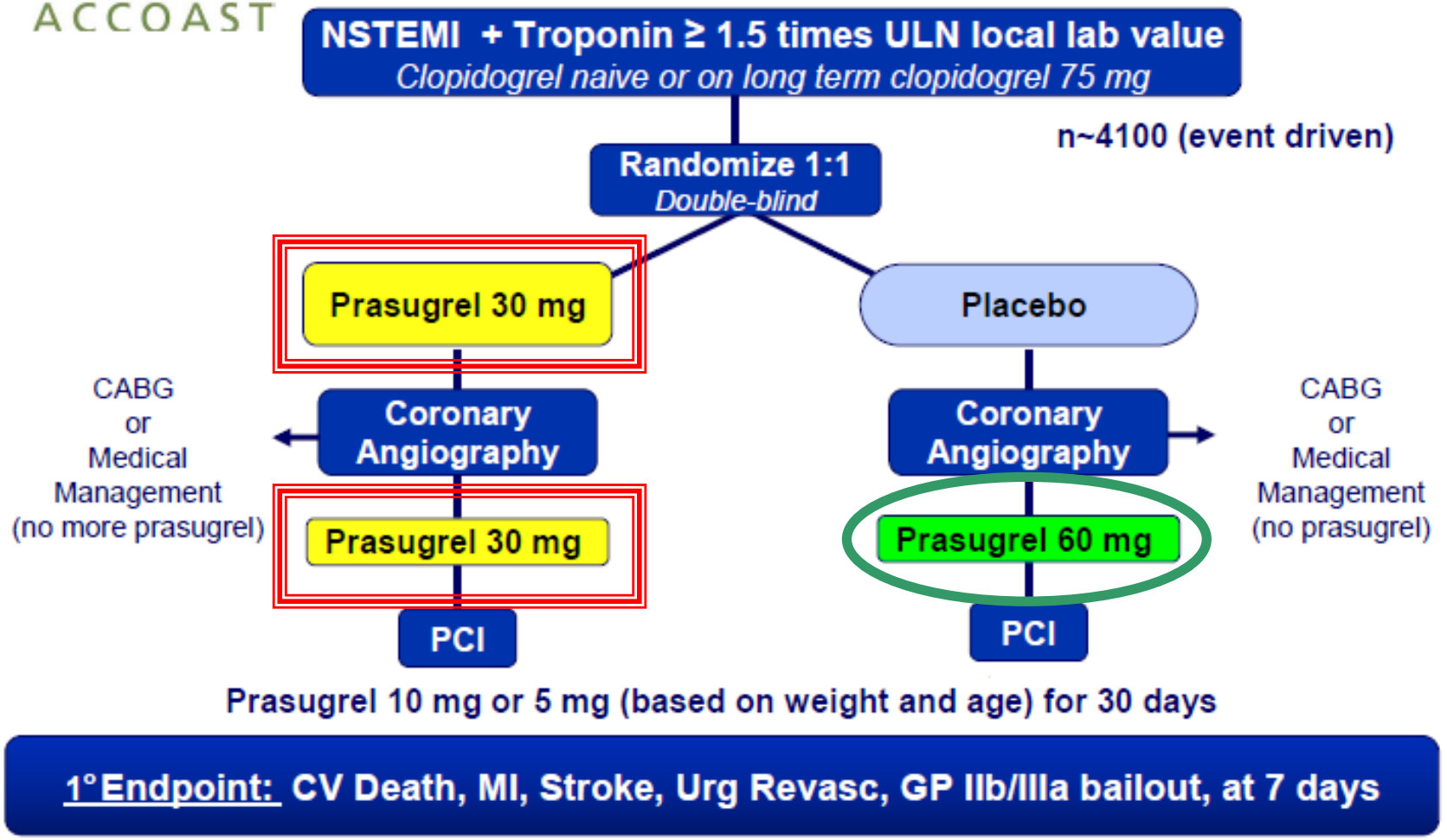
PCI-CURE
***(Lancet* 2001)**
6 Days



* In addition to other standard therapies.
* Patients did not receive open-label thienopyridine before PCI.

Mehta SR et al for the CURE Investigators. Lancet. 2002

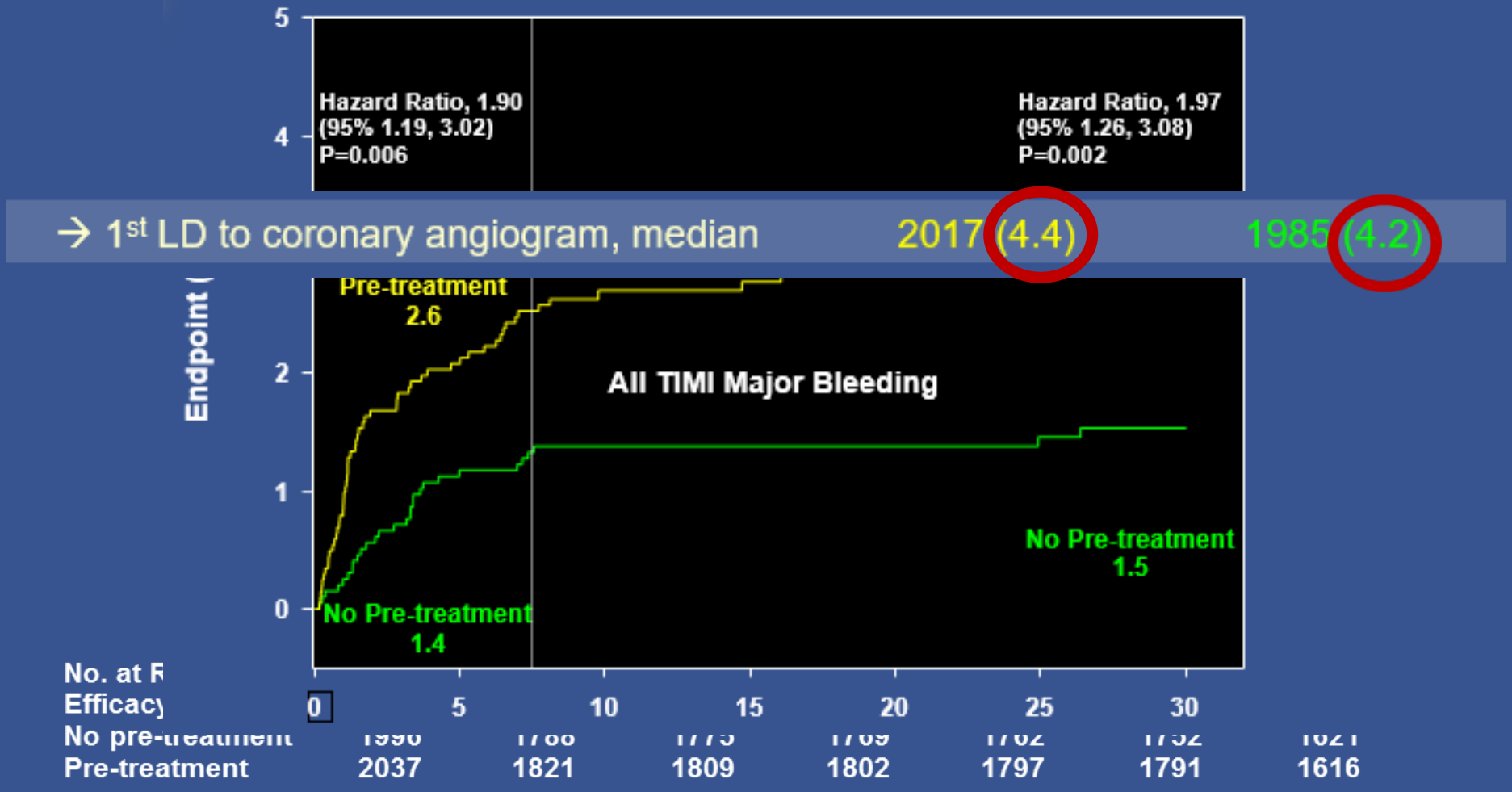
ACCOAST Design Schema



Montalescot G et al. Am Heart J 2011;161:650

1° Efficacy End Point @ 7 + 30 days (All Patients)

All TIMI (CABG or non-CABG) Major Bleeding (All Treated patients)



Montalescot et al. *NEJM* 2013; epub Sept 1

EYESHOT Registry

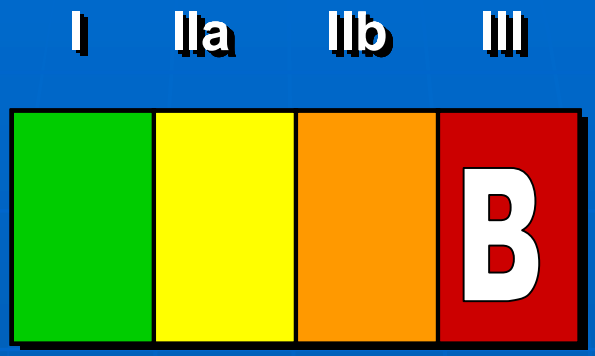
NSTE-ACS: Timing to Coro

NSTE-ACS

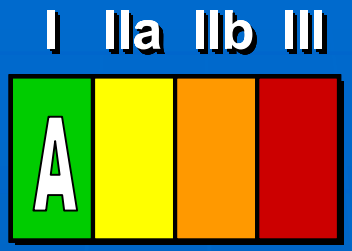
Mediana 33.9 hrs

Mediana
57.5 [28.0-97.2] hrs

Mediana
29.4 [15.7-64.8] hrs



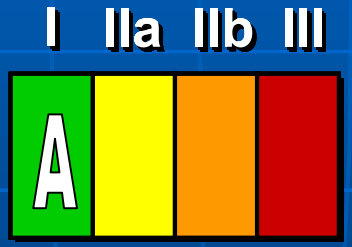
It is <u>not recommended</u> to administer prasugrel in patients in whom coronary anatomy is not known



2011 ESC Guidelines

A P2Y12 inhibitor should be added to aspirin as soon as possible and maintained over 12 months, unless there are contraindications such as excessive risk of bleeding

2014 ESC Guidelines on myocardial revascularization

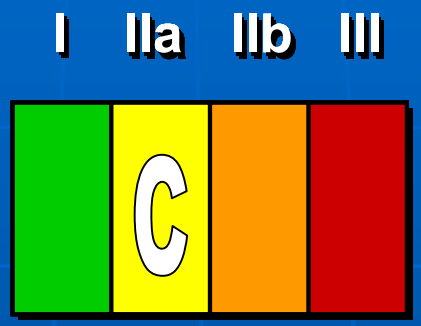


20[illegible]

disappeared

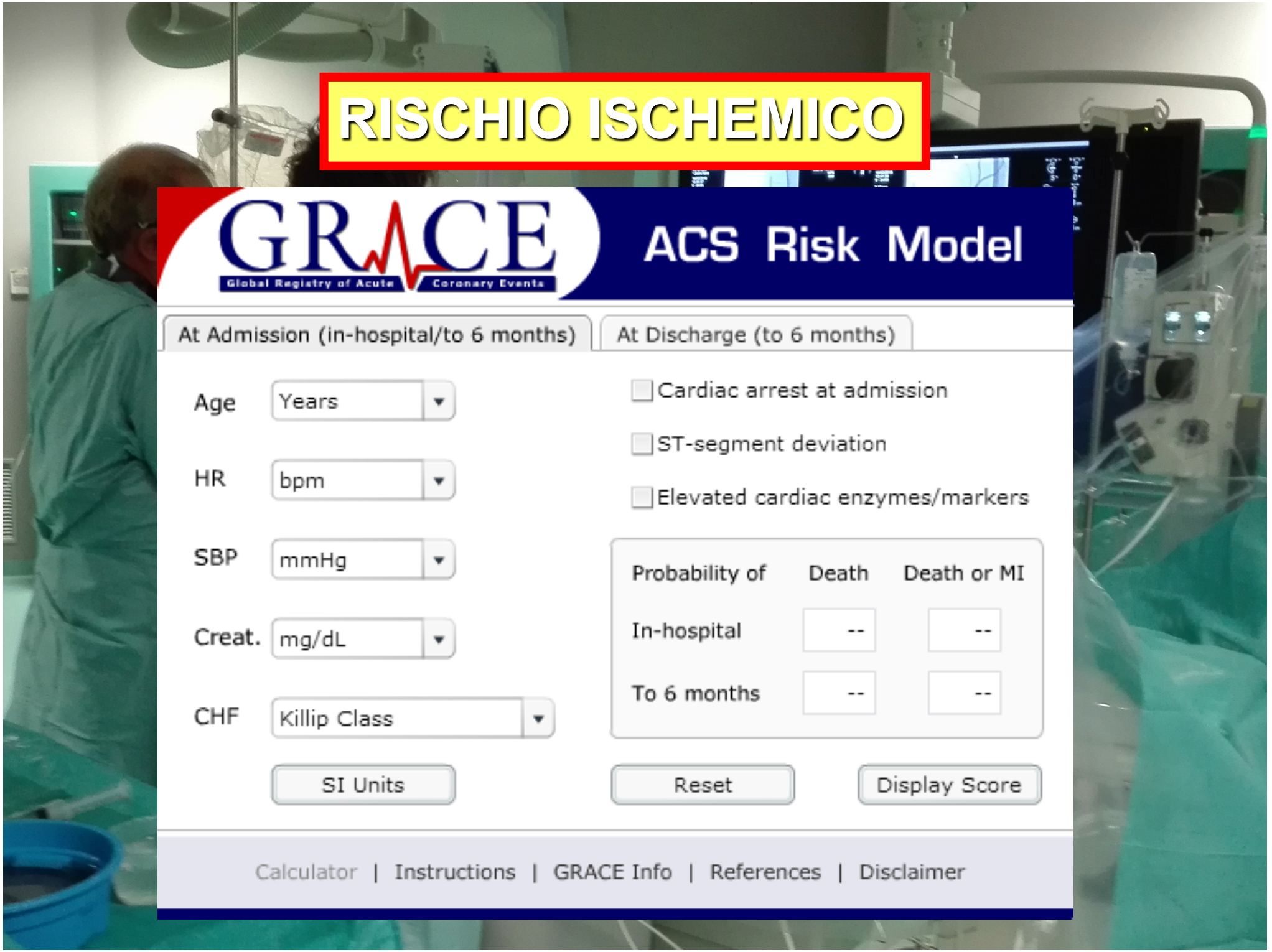
A P2Y12 inhibitor is recommended, in addition to aspirin, for 12 months unless there are contraindications such as excessive risk of bleeds

2017 ESC focused update on dual antiplatelet therapy



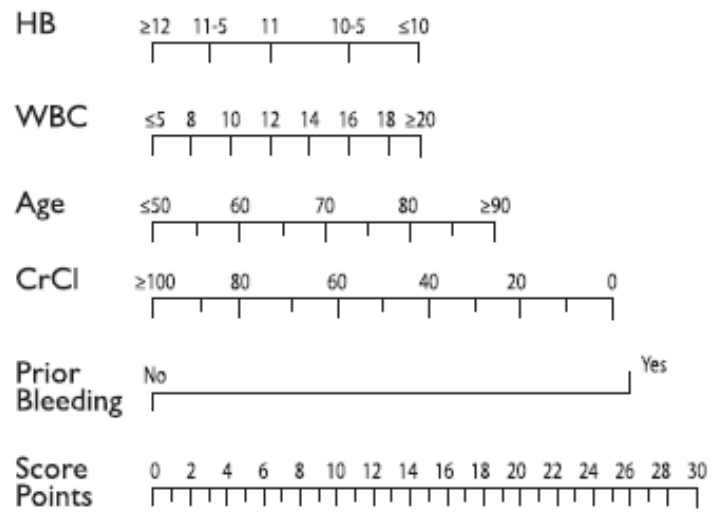
In patients with NSTE-ACS undergoing invasive management, ticagrelor administration (180 mg loading dose, 90 mg twice daily), or clopidogrel (600 mg loading dose, 75 mg daily dose) if ticagrelor is not an option, should be considered **as soon as** the diagnosis is established.

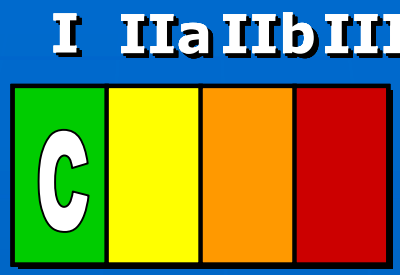
RISCHIO ISCHEMICO



RISCHIO EMORRAGICO

PRETREATMENT?

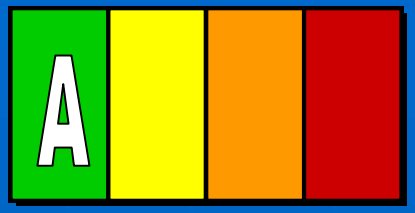
	PRECISE-DAPT score[18]
Time of use	At the time of coronary stenting
DAPT duration strategies assessed	Short DAPT (3–6 months) vs. Standard/long DAPT (12–24 months)
Score calculation[a]	
Score range	0 to 100 points
Decision making cut-off suggested	Score ≥25 → Short DAPT Score <25 → Standard/long DAPT



An immediate invasive strategy (<2h) is recommended in patients with at least one of the following very-high-risk criteria

Very-high-risk criteria
• 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-T wave changes, particularly with intermittent ST-elevation

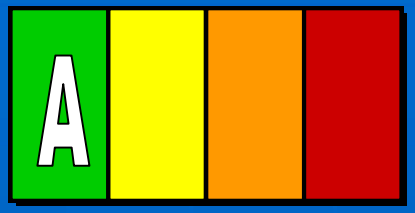
I IIa IIb III



An early invasive strategy (<24 h) is recommended in patients with at least one of the following high-risk criteria

High-risk criteria
• Rise or fall in cardiac troponin compatible with MI
• Dynamic ST- or T-wave changes (symptomatic or silent)
• GRACE score >140

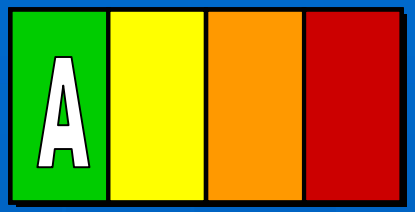
I IIa IIb III



An invasive strategy (<72 h) is recommended in patients with at least one of the following intermediate-risk criteria

Intermediate-risk criteria
• Diabetes mellitus
• Renal insufficiency (eGFR <60 mL/min/1.73 m²)
• LVEF <40% or congestive heart failure
• Early post-infarction angina
• Prior PCI
• Prior CABG
• GRACE risk score >109 and <140

I IIa IIb III



SELECTIVE INVASIVE STRATEGY

In patients with none of the above mentioned risk criteria and no recurrent symptoms, non-invasive testing for ischaemia (preferably with imaging) is recommended before deciding on an invasive evaluation.