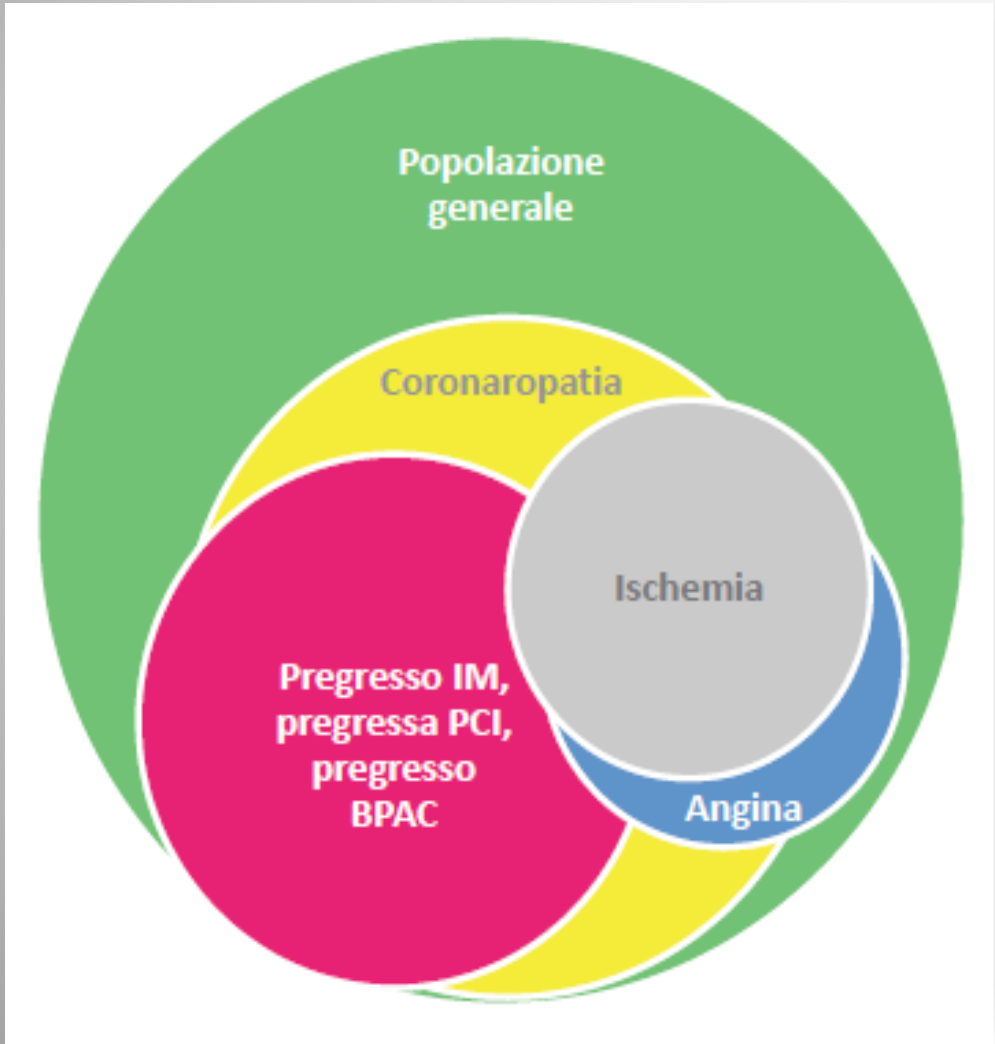
Giornate Mediche di Santa Maria Nuova
IL DANNO TISSUTALE ISCHEMICO
18-19 Ottobre 2018

Terapia farmacologica antischemica: quale, quando e per quanto

Dott. Francesca Sani
Ospedale San Giovanni di Dio

Terapia farmacologica antischemica: quale, quando e per quanto



- La cardiopatia ischemica cronica rappresenta un problema concreto e rilevante nella realtà italiana.

- Considerando l'aumento della popolazione anziana, si stima che in Italia siano presenti circa 5 milioni di pazienti coronaropatici, di cui 1,5 milioni con angina stabile.

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Vascular Biology Working Group

COURAGE

Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation

COURAGE was designed to evaluate whether PCI plus optimal medical therapy, as initial management strategy, reduces risk of major CV events compared with optimal medical therapy alone in stable CAD patients

VBWG

COURAGE: Study design

AHA/ACC Class I/II indications for PCI, suitable coronary artery anatomy + ≥70% stenosis in ≥1 proximal epicardial vessel + objective evidence of ischemia (or ≥80% stenosis + CCS class III angina without provocation testing)

Optimal medical therapy* + PCI (n = 1149)

Randomized

Optimal medical therapy (n = 1138)

Primary outcomes: All-cause mortality, nonfatal MI

Secondary outcomes: Death, MI, stroke; ACS hospitalization

Follow-up: Median 4.6 years

*Intensive pharmacologic therapy + lifestyle intervention
CCS = Canadian Cardiovascular Society

Boden WE et al. *Am Heart J.* 2006;151:1173-9.
Boden WE et al. *N Engl J Med.* 2007;356:1503-16.

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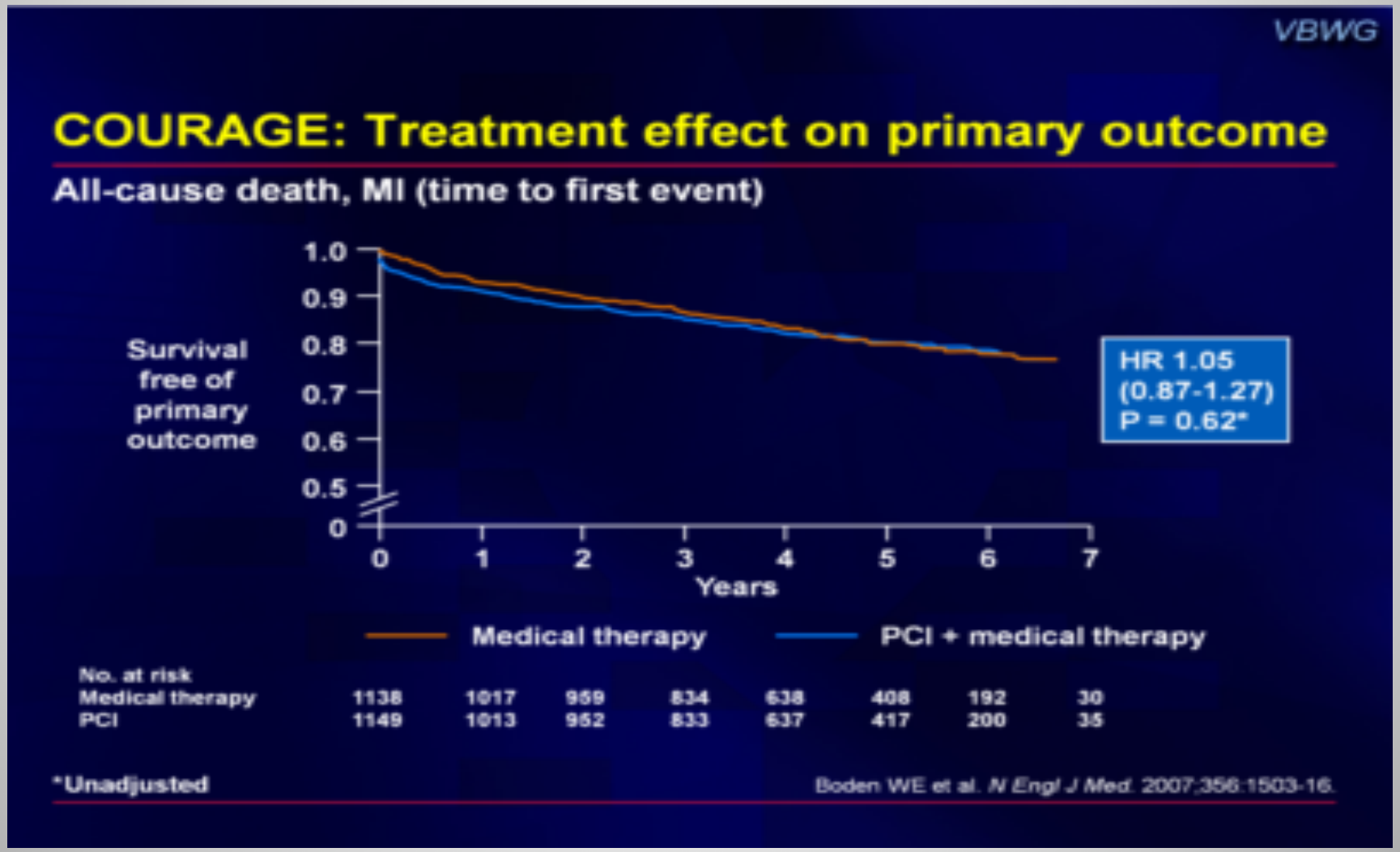

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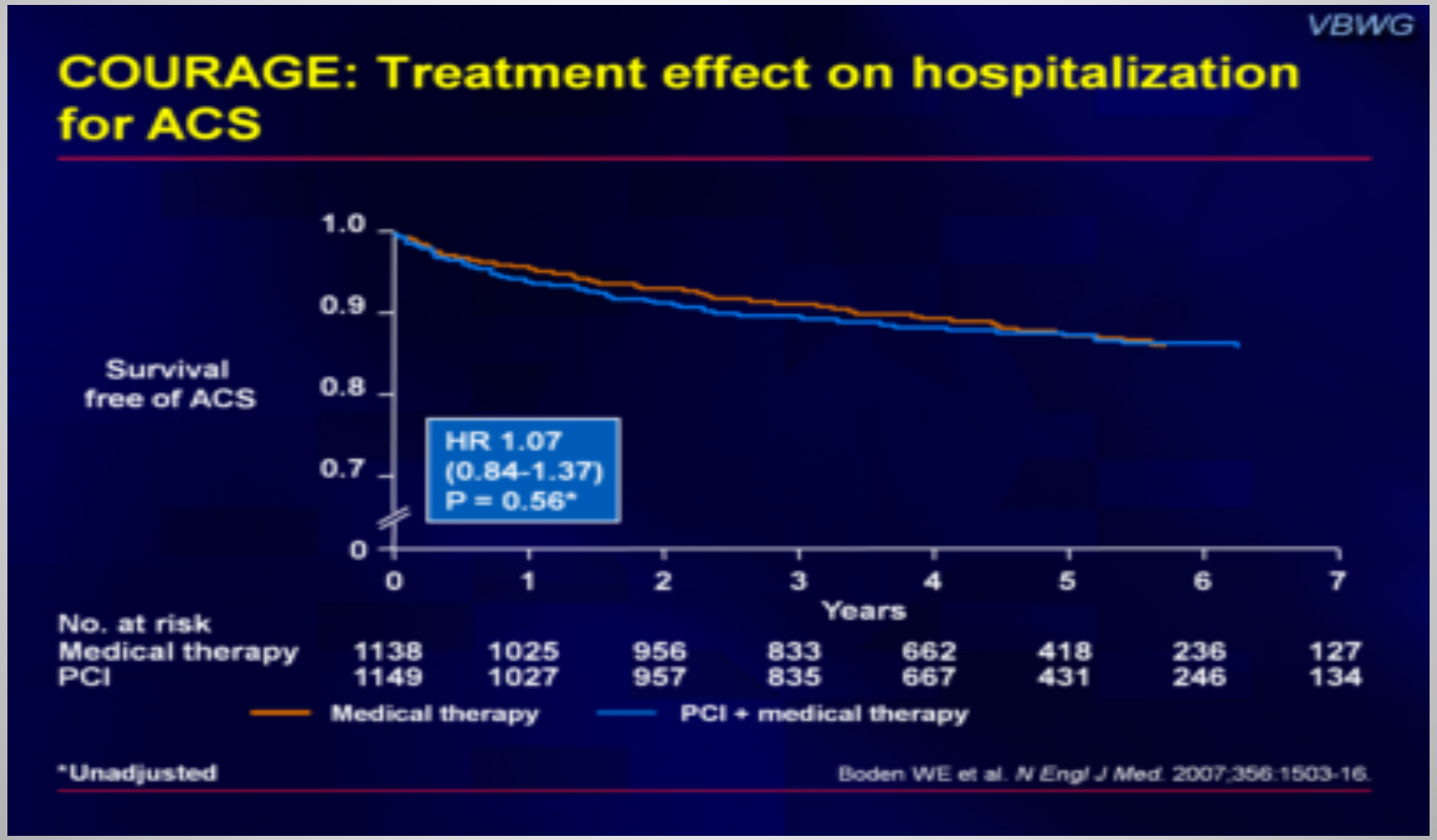

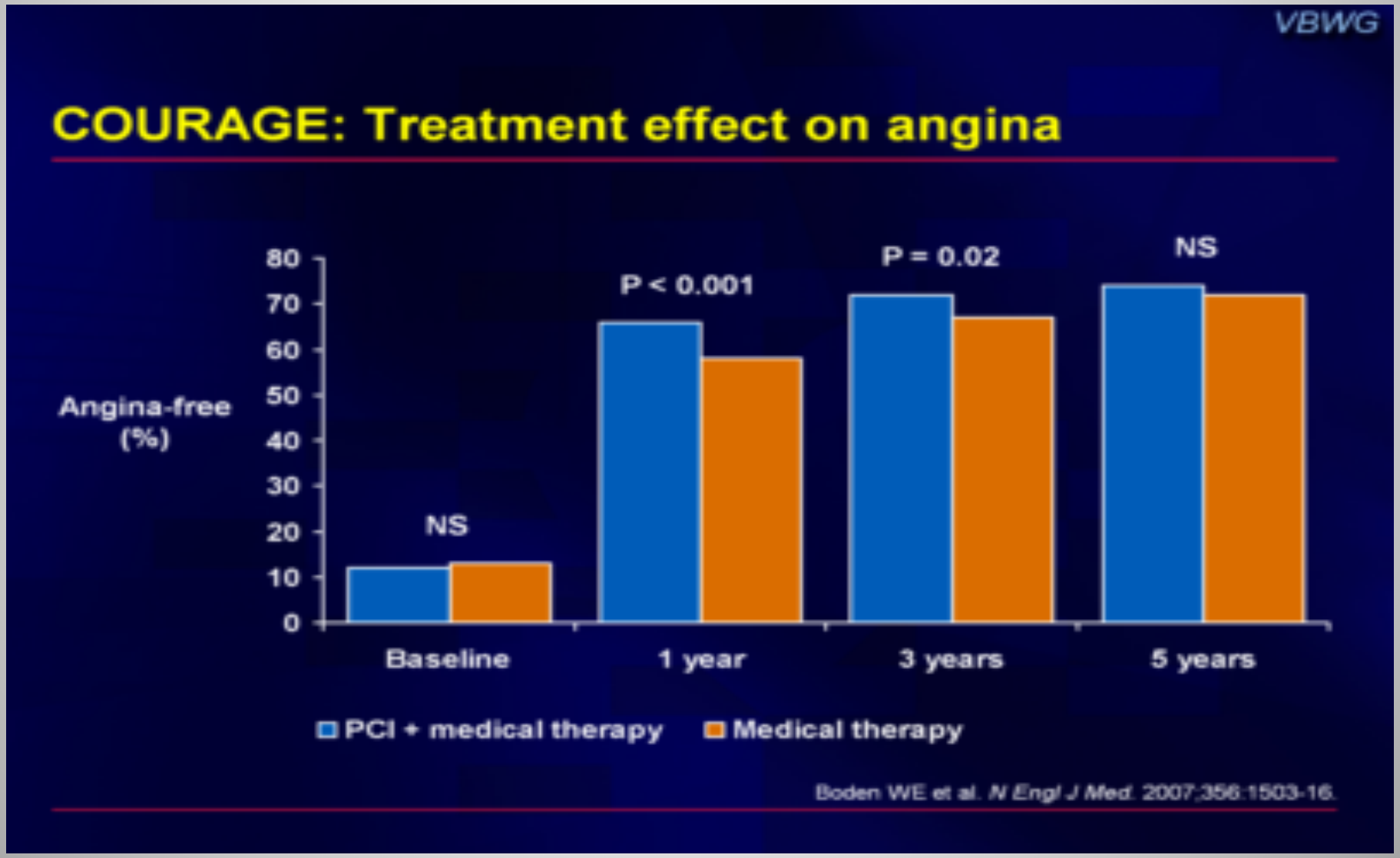
VBWG
COURAGE: Treatment effect on angina
Angina-free (%)
80
70
60
50
40
30
20
10
0
NS
P < 0.001
P = 0.02
NS
Baseline
1 year
3 years
5 years
PCI + medical therapy
Medical therapy
Boden WE et al. N Engl J Med. 2007;356:1503-16.

European Heart Journal (2013) **34**, 2949–3003
doi:10.1093/eurheartj/eht296

ESC GUIDELINES

2013 ESC guidelines on the management of stable coronary artery disease

The Task Force on the management of stable coronary artery disease of the European Society of Cardiology

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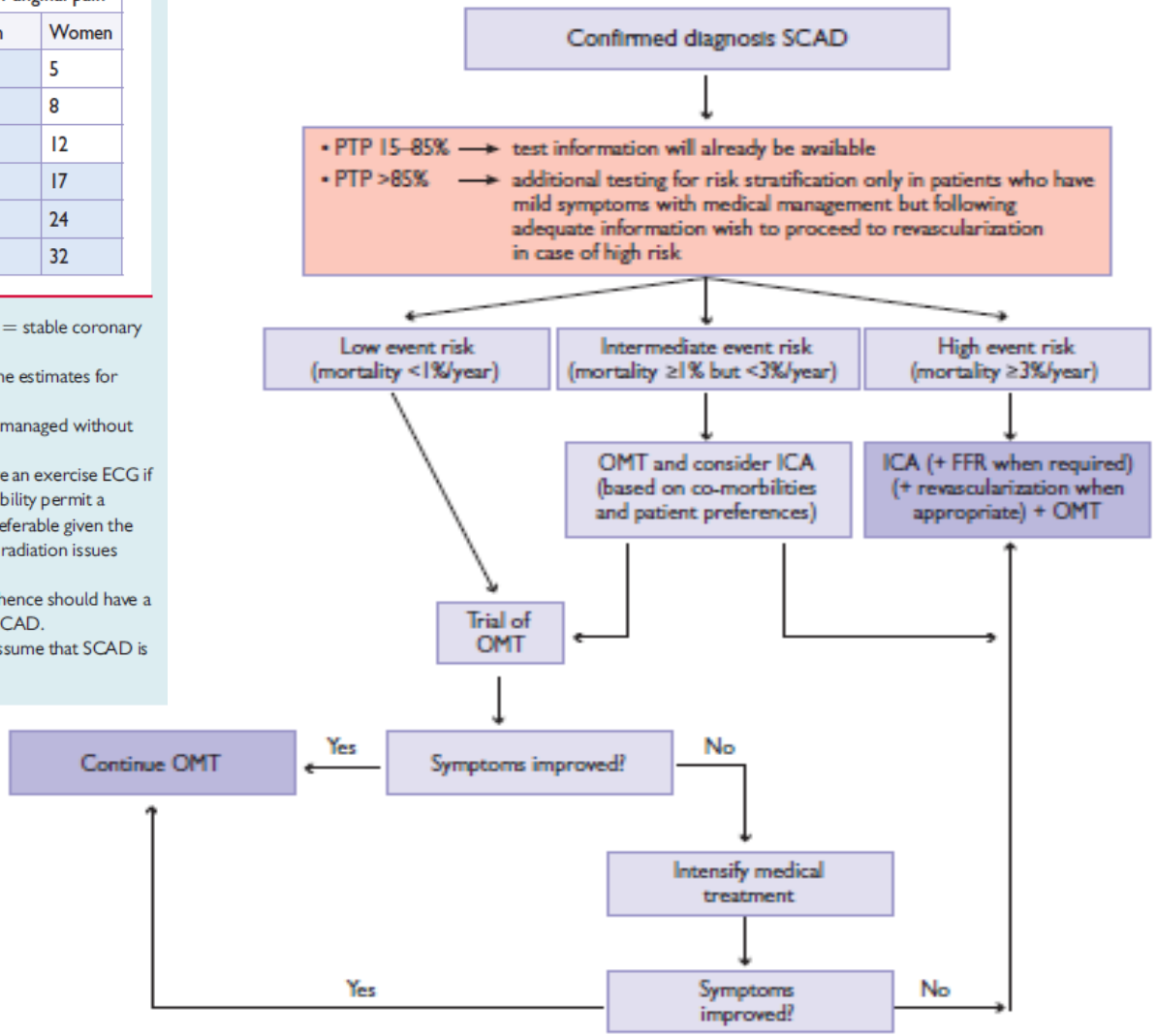
	Typical angina		Atypical angina		Non-anginal pain	
Age	Men	Women	Men	Women	Men	Women
30–39	59	28	29	10	18	5
40–49	69	37	38	14	25	8
50–59	77	47	49	20	34	12
60–69	84	58	59	28	44	17
70–79	89	68	69	37	54	24
>80	93	76	78	47	65	32

ECG = electrocardiogram; PTP = pre-test probability; SCAD = stable coronary artery disease.
[a] Probabilities of obstructive coronary disease shown reflect the estimates for patients aged 35, 45, 55, 65, 75 and 85 years.
• Groups in white boxes have a PTP <15% and hence can be managed without further testing.
• Groups in blue boxes have a PTP of 15–65%. They could have an exercise ECG if feasible as the initial test. However, if local expertise and availability permit a non-invasive imaging based test for ischaemia this would be preferable given the superior diagnostic capabilities of such tests. In young patients radiation issues should be considered.
• Groups in light red boxes have PTPs between 66–85% and hence should have a non-invasive imaging functional test for making a diagnosis of SCAD.
• In groups in dark red boxes the PTP is >85% and one can assume that SCAD is present. They need risk stratification only.



POSITION PAPER

La posizione della Società Italiana di Cardiologia Invasiva (SICI-GISE) sulle indicazioni alla coronarografia nel paziente con angina stabile

Alfredo Marchese[1], Roberta Rossini[2], Marco Basile[1], Francesco Bedogni[3], Gian Battista Danzi[4], Giuseppe Musumeci[2], Valeria Paradies[1], Emanuela Piccaluga[5], Gennaro Sardella[6], Ferdinando Varbella[7], Arturo Giordano[8], Sergio Berti[9]

- PTP non tiene di conto delle caratteristiche del paziente
- La diagnosi di angina è una diagnosi clinica
- Nella stima delle complicanze della coronarografia sono citati studi datati
- COURAGE non riflette il mondo reale (popolazione a basso rischio, prev.BMS)
- Obiettivo PCI agire sui sintomi e migliorare qualità di vita

Conclusioni: pz con angina tipica e plurimi fattori di rischio o nei diabetici con sintomi fortemente sospetti

Indicazione a coronarografia, sia per stratificazione prognostica, sia per eliminare il sintomo e migliorare la qualità di vita

Percutaneous coronary intervention in stable angina (ORBITA): a double-blind, randomised controlled trial

*Rasha Al-Lamee, David Thompson, Hakim-Moulay Dehbi, Sayan Sen, Kare Tang, John Davies, Thomas Keeble, Michael Mielewczik, Raffi Kaprielian, Iqbal S Malik, Sukhjinder S Nijjer, Ricardo Petraco, Christopher Cook, Yousif Ahmad, James Howard, Christopher Baker, Andrew Sharp, Robert Gerber, Suneel Talwar, Ravi Assomull, Jamil Mayet, Roland Wensel, David Collier, Matthew Shun-Shin, Simon A Thom, Justin E Davies, Darrel P Francis, on behalf of the ORBITA investigators**

Principal hypothesis:
Symptom relief in stable angina

PCI increases exercise time more than placebo procedure

Primary endpoint

Difference in exercise time increment between the arms

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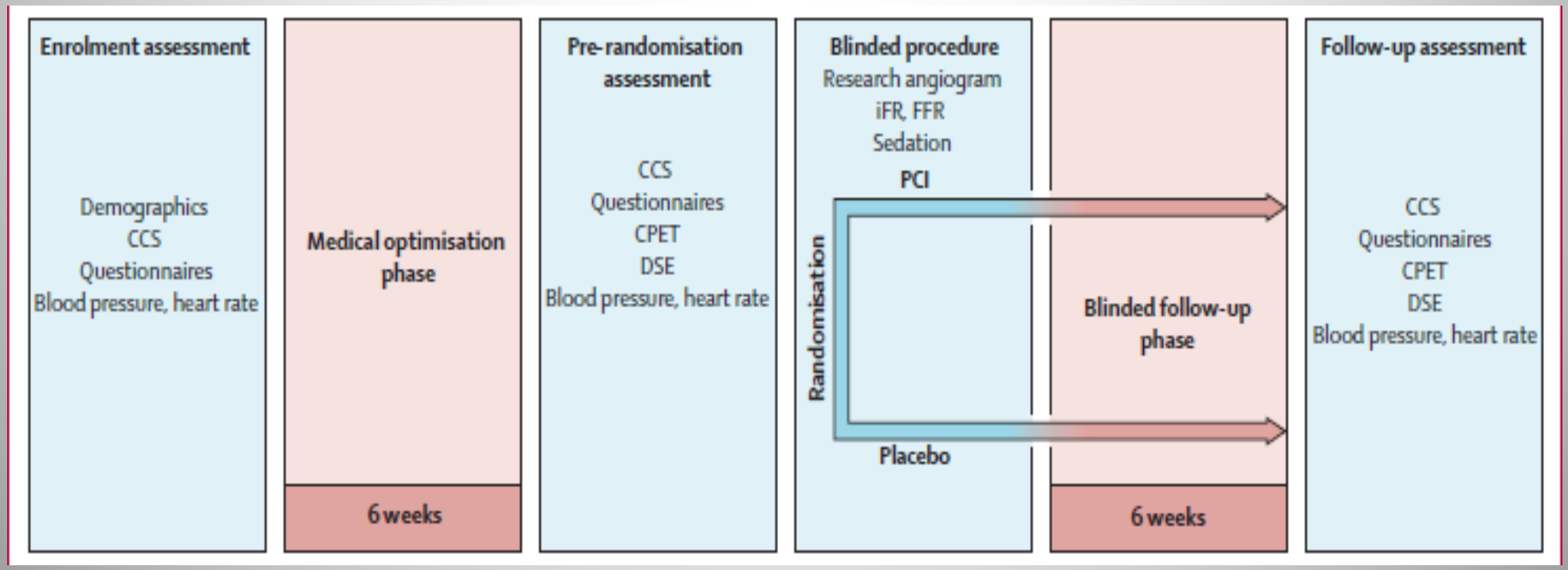
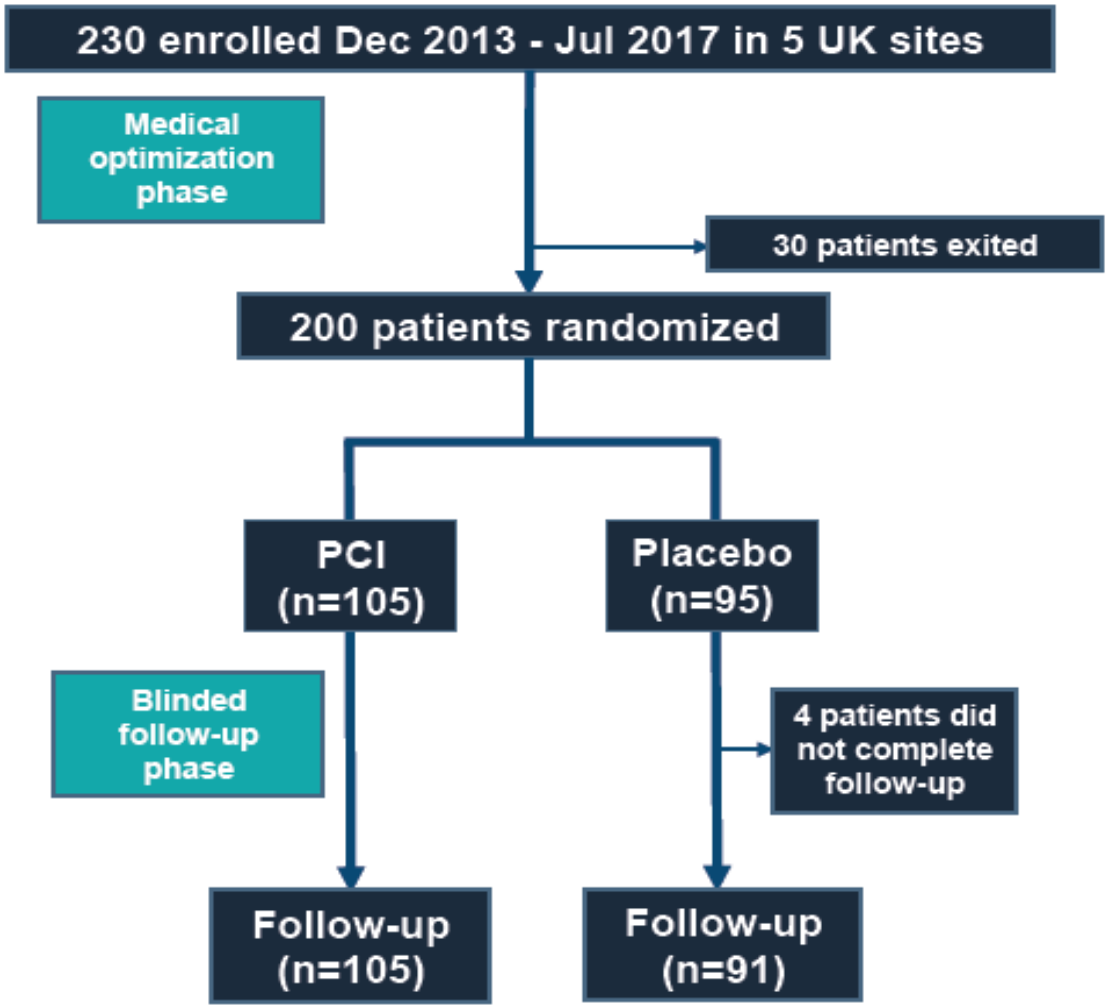
Inclusion criteria

- Stable angina
- One or more ≥ 70% stenosis in a single vessel
- Suitable for PCI

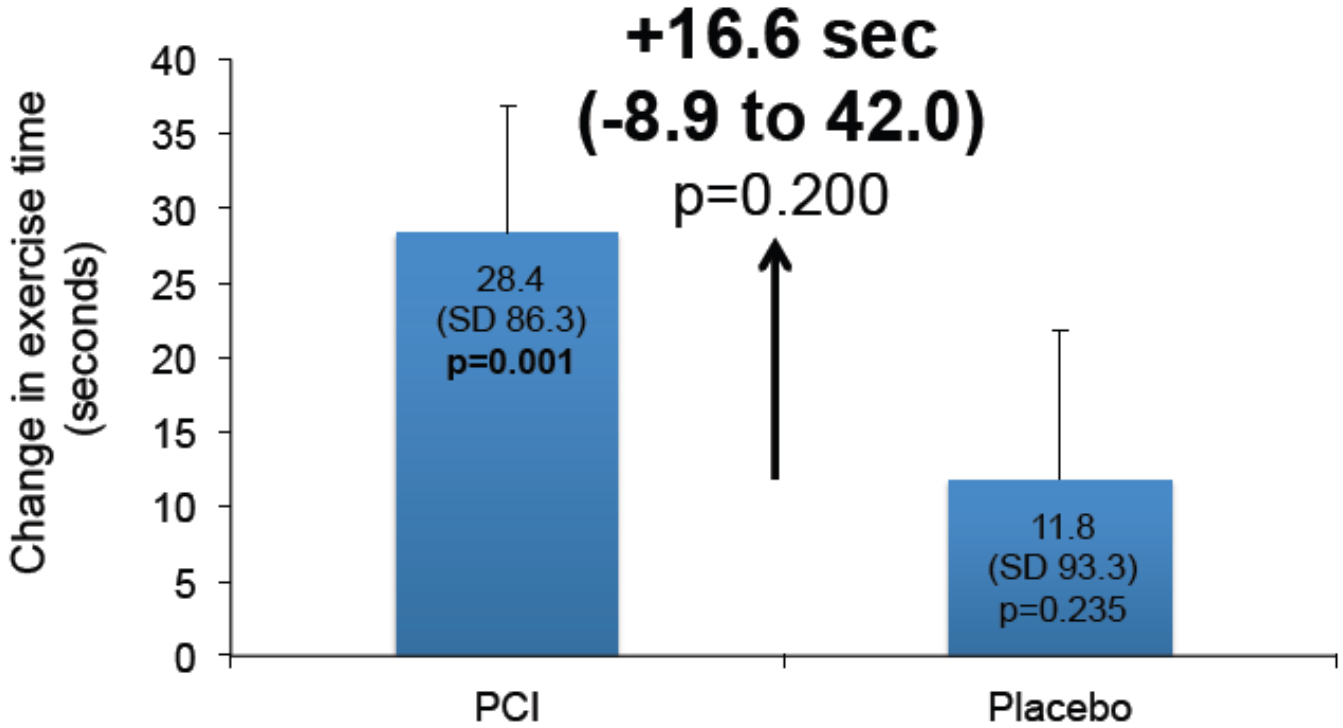


ORBITA trial



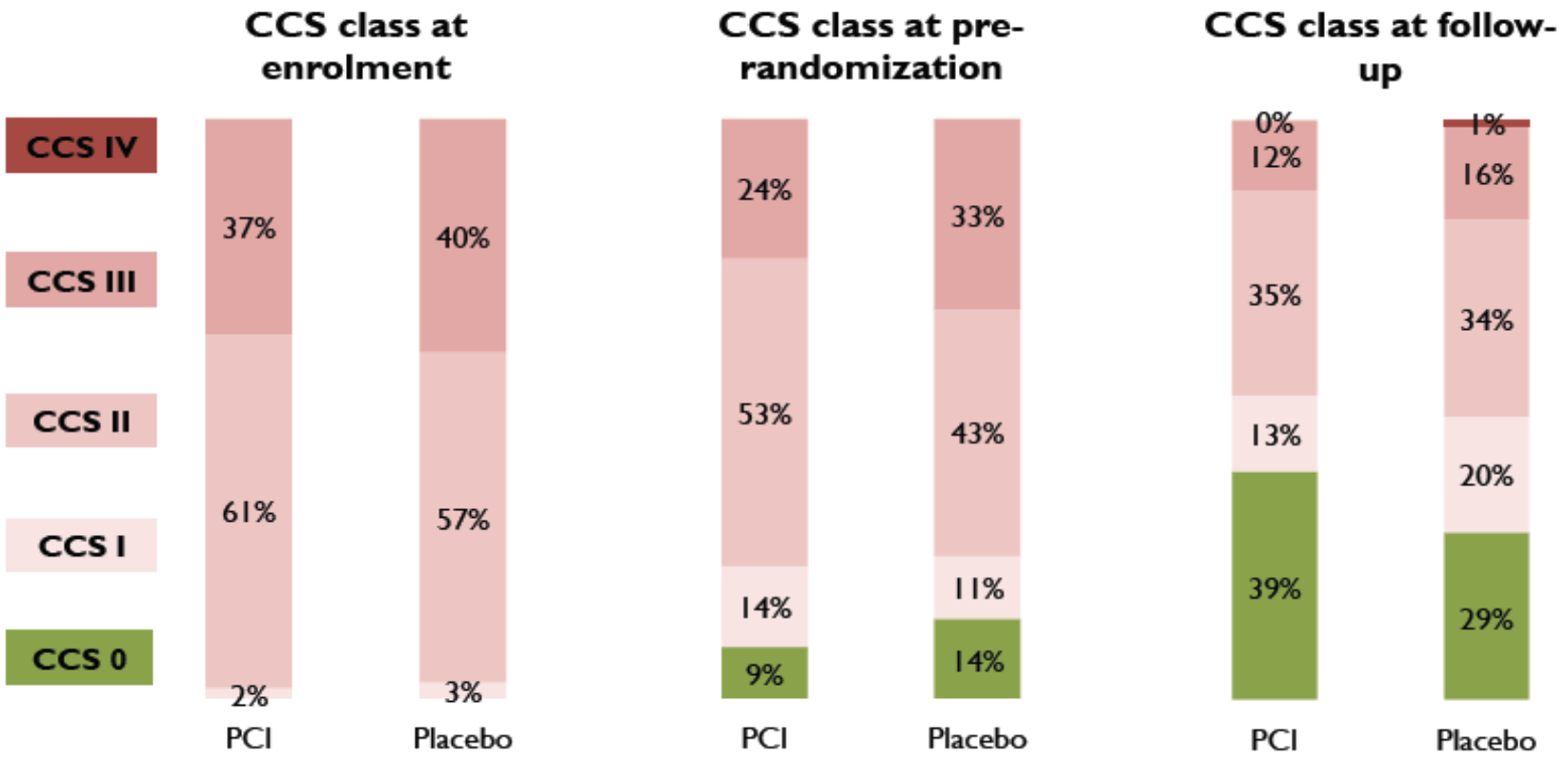
Primary endpoint result

Change in total exercise time



Secondary endpoint results

CCS class improved in both groups



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ESC European Society of Cardiology

European Heart Journal (2018) **00**, 1–96
doi:10.1093/eurheartj/ehy394

ESC/EACTS GUIDELINES

2018 ESC/EACTS Guidelines on myocardial revascularization

The Task Force on myocardial revascularization of the European Society of Cardiology (ESC) and European Association for Cardio-Thoracic Surgery (EACTS)

Developed with the special contribution of the European Association for Percutaneous Cardiovascular Interventions (EAPCI)

Indications for revascularization in patients with stable angina or silent ischaemia

Extent of CAD (anatomical and/or functional)		Class[a]	Level[b]
For prognosis	Left main disease with stenosis >50%.[c 68–71]	I	A
	Proximal LAD stenosis >50%.[c 62,68,70,72]	I	A
	Two- or three-vessel disease with stenosis >50% with impaired LV function (LVEF ≤35%).[c 61,62,68,70,73–83]	I	A
	Large area of ischaemia detected by functional testing (>10% LV) or abnormal invasive FFR.[d 24,59,84–90]	I	B
	Single remaining patent coronary artery with stenosis >50%.[c]	I	C
For symptoms	Haemodynamically significant coronary stenosis[c] in the presence of limiting angina or angina equivalent, with insufficient response to optimized medical therapy.[e 24,63,91–97]	I	A

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Qual'è la terapia ottimale secondo le Linee Guida???

Ottimal medical treatment indicates at least **one** drug for angina/ischemia relief plus drugs for event prevention

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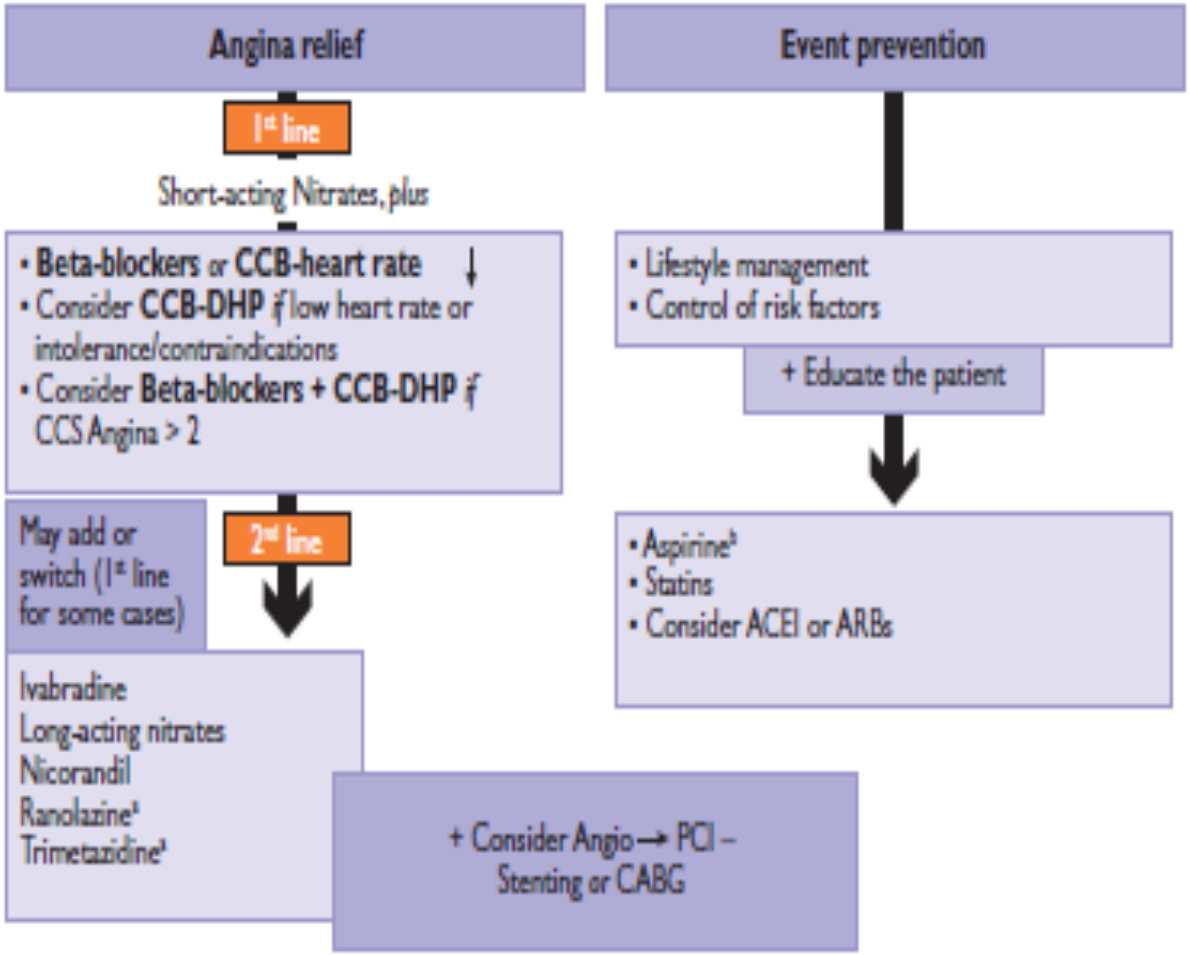
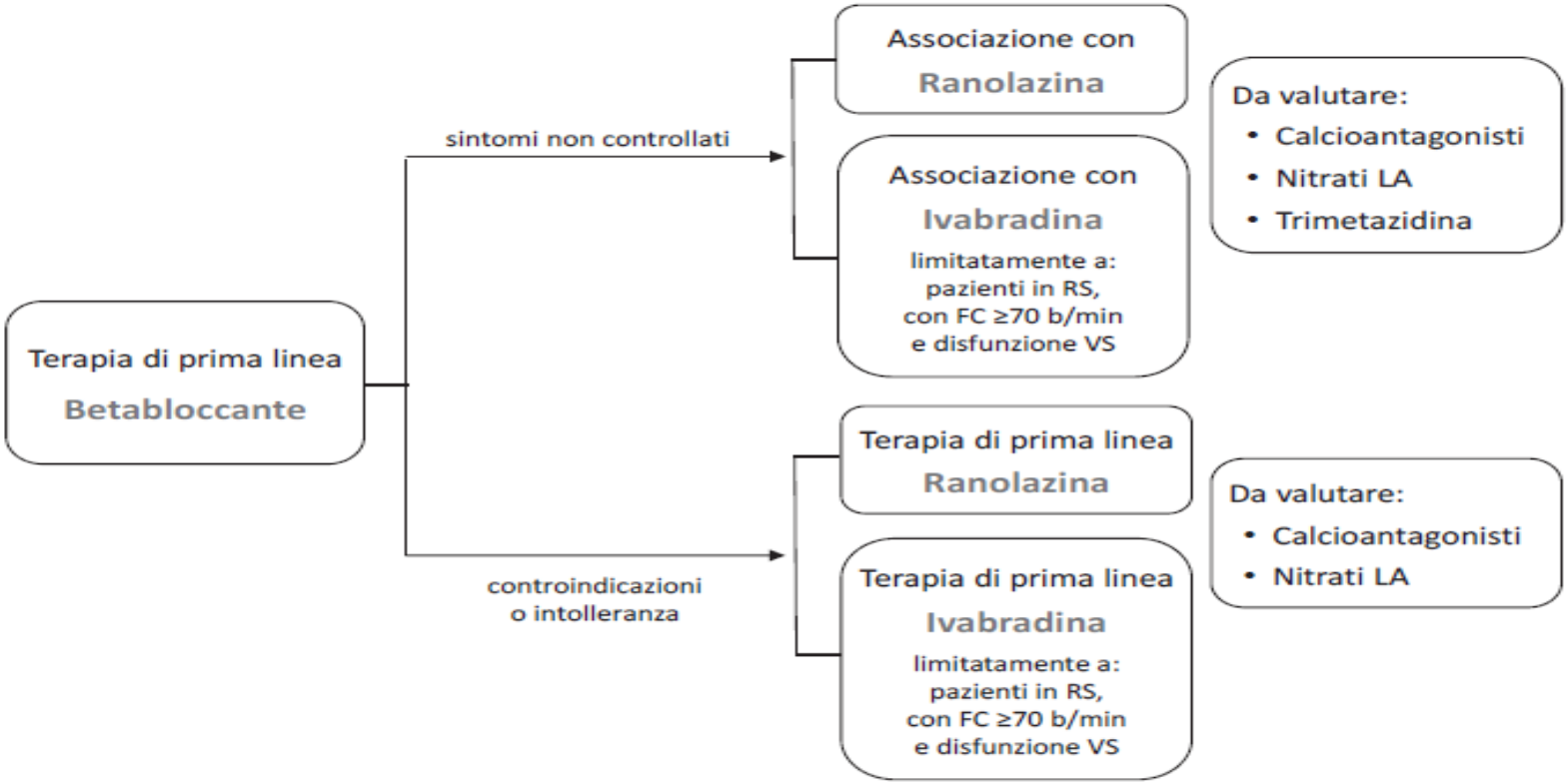
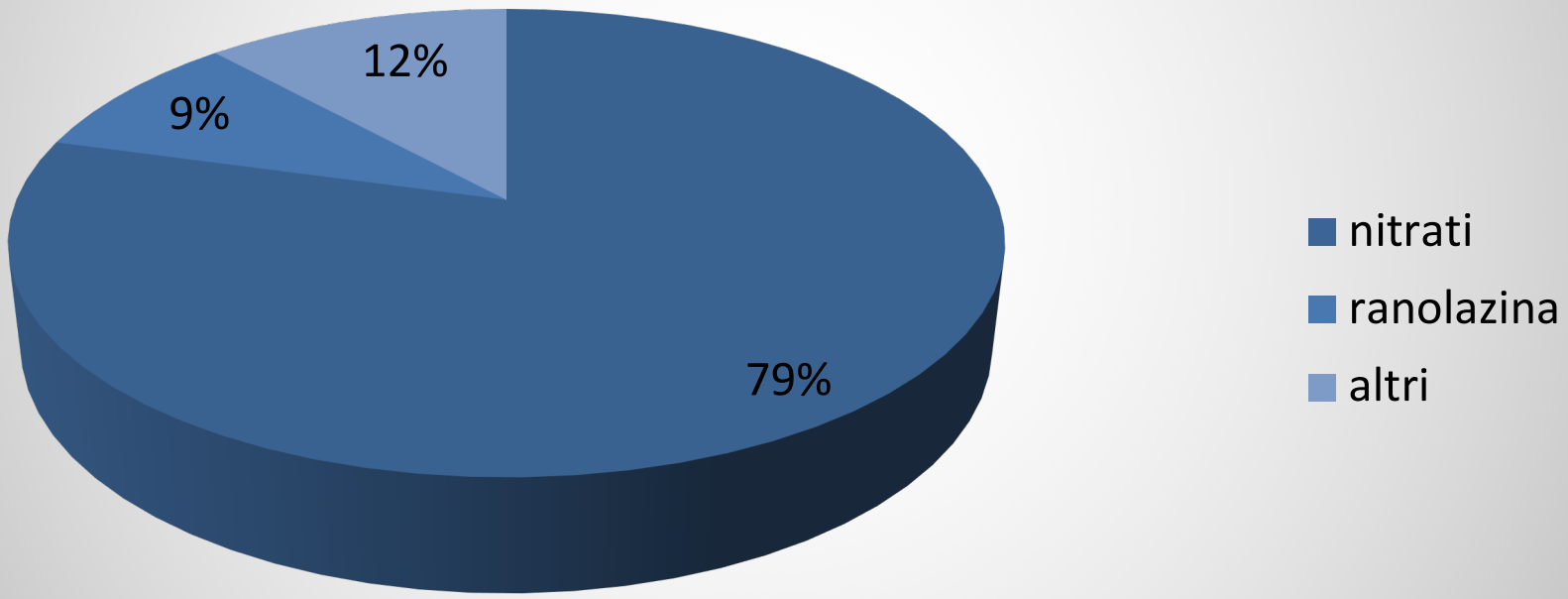


Documento di consenso ANMCO/GICR-IACPR/SICI-GISE: La gestione clinica del paziente con cardiopatia ischemica cronica



È quello che facciamo nella pratica clinica???



Utilizzo dei farmaci nel paziente in rivalutazione per dolore anginoso

Medical Audit 2014

EXPERT CONSENSUS DOCUMENT

A 'diamond' approach to personalized treatment of angina

Roberto Ferrari[1,2], Paolo G. Camici[3], Filippo Crea[4], Nicolas Danchin[5], Kim Fox[6], Aldo P. Maggioni[7], Athanasios J. Manolis[8], Mario Marzilli[9,10], Giuseppe M. C. Rosano[11,12] and José L. Lopez-Sendon[13]

Nature, February 2018

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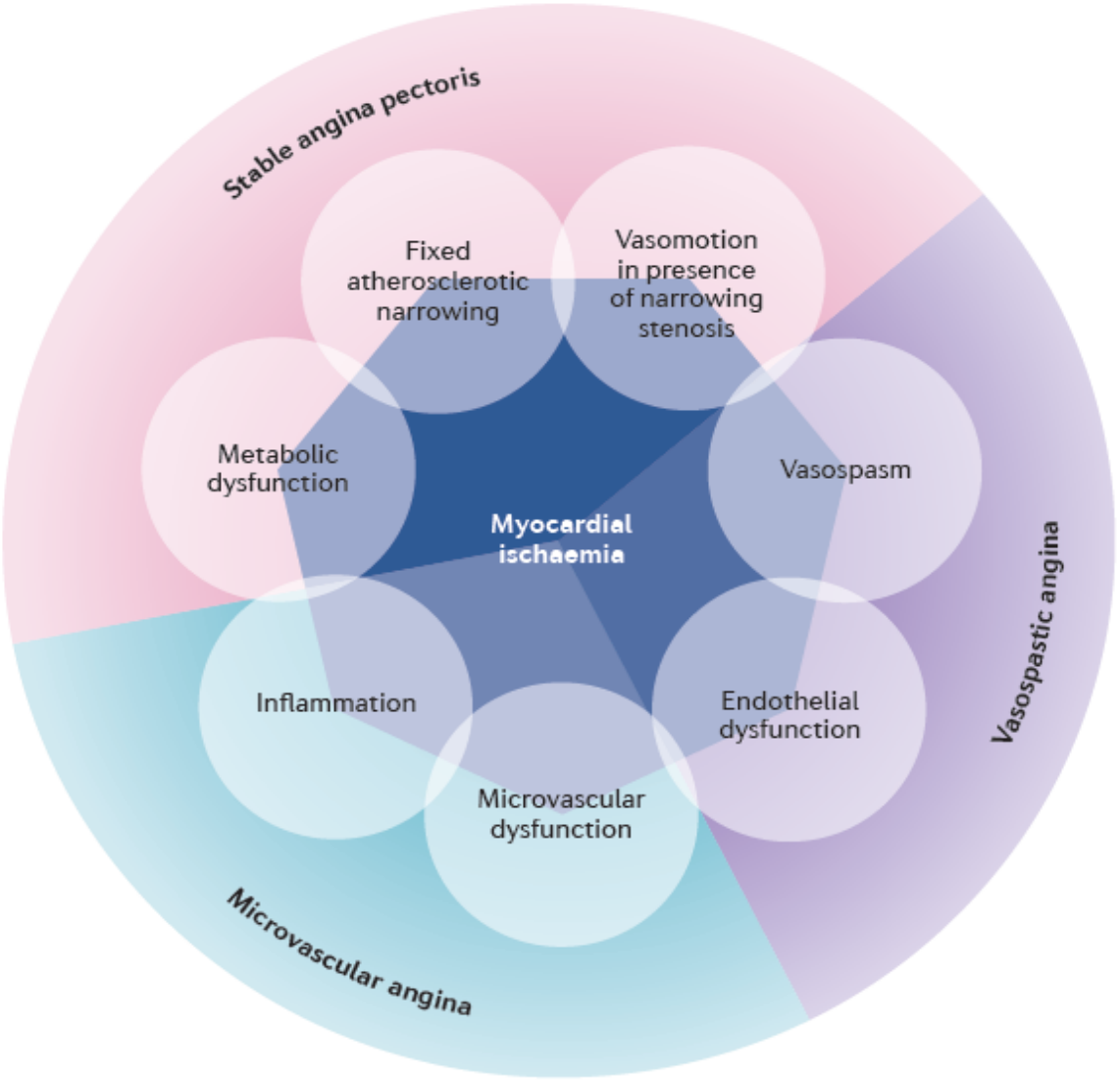

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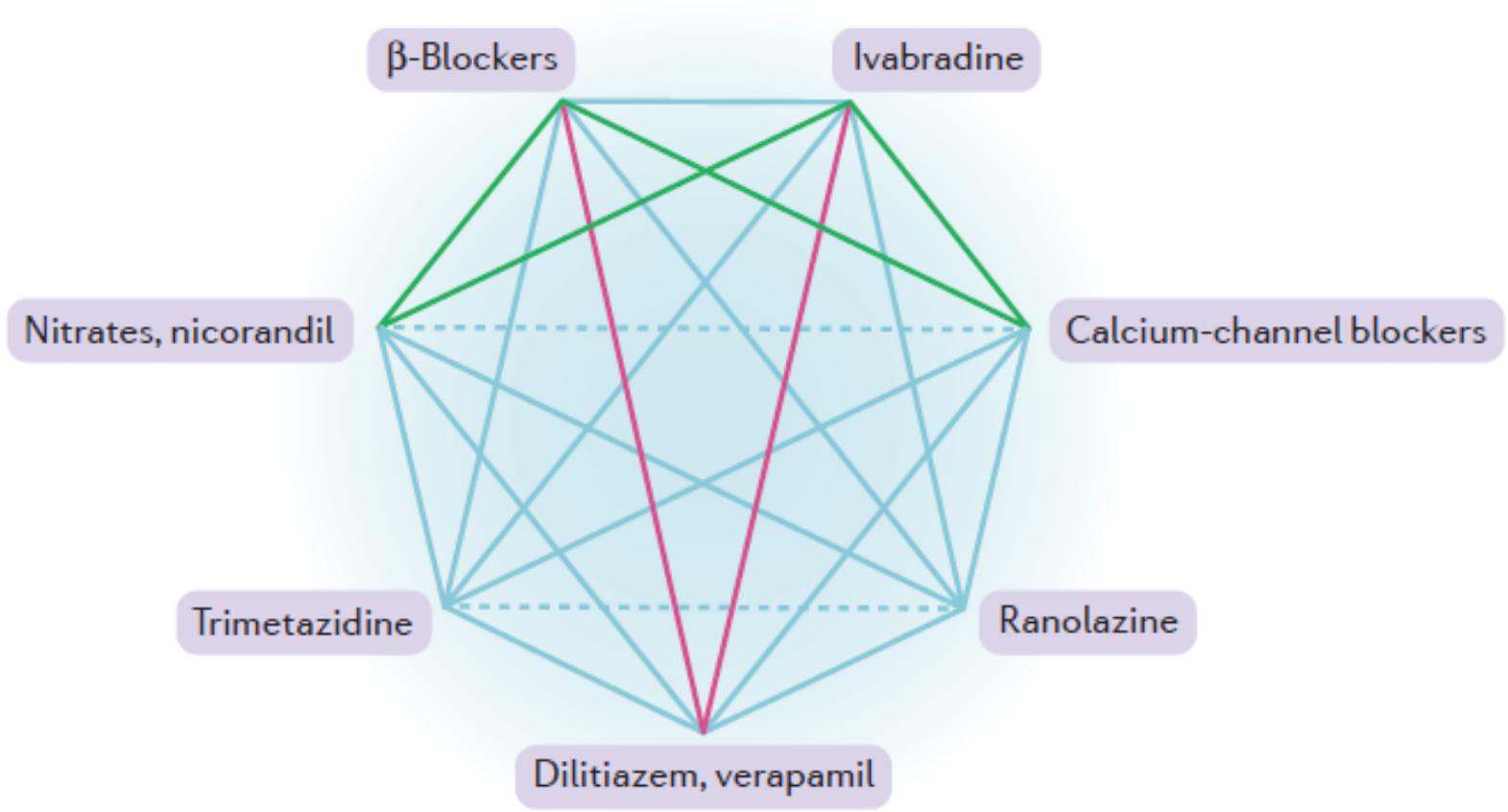

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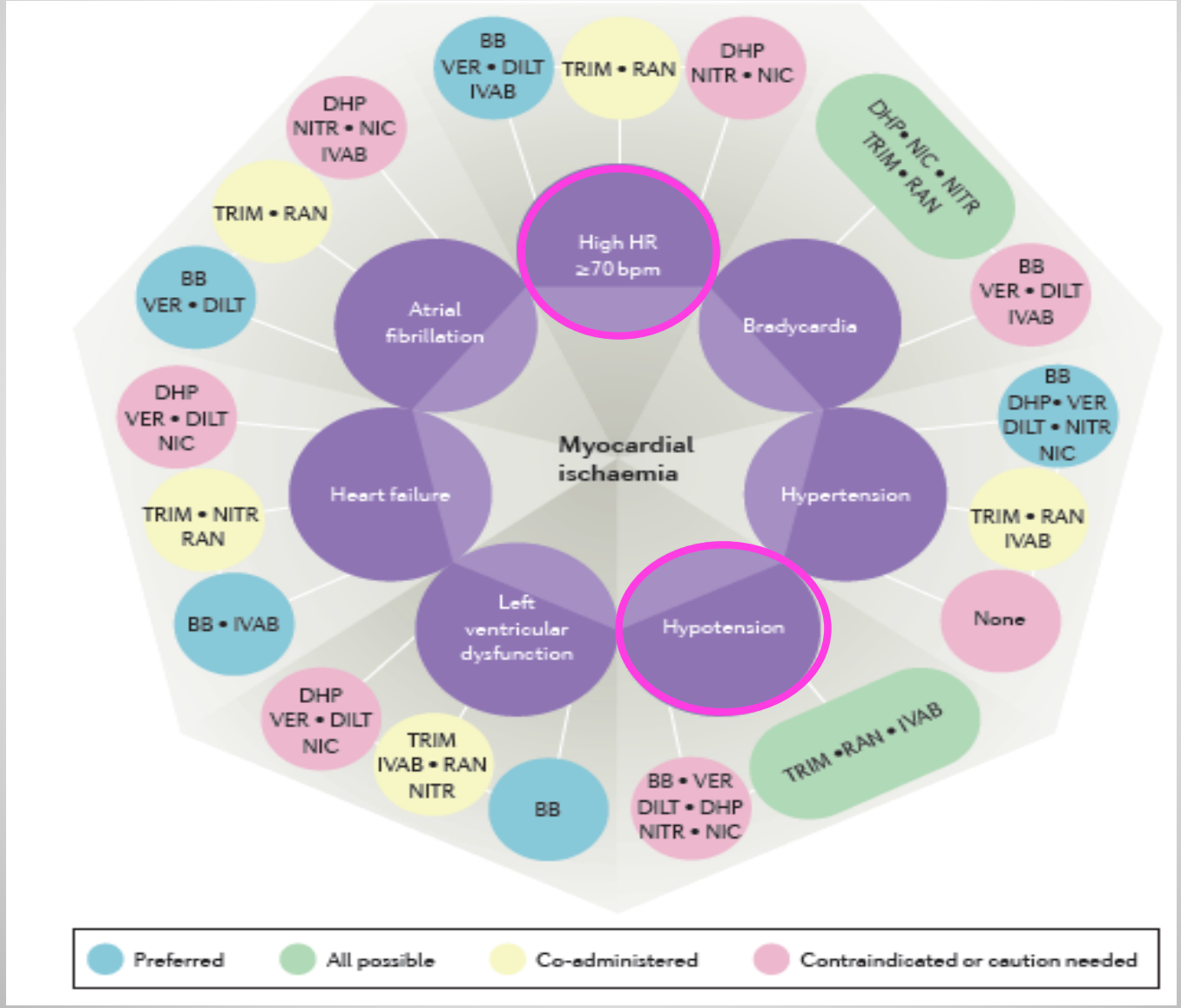

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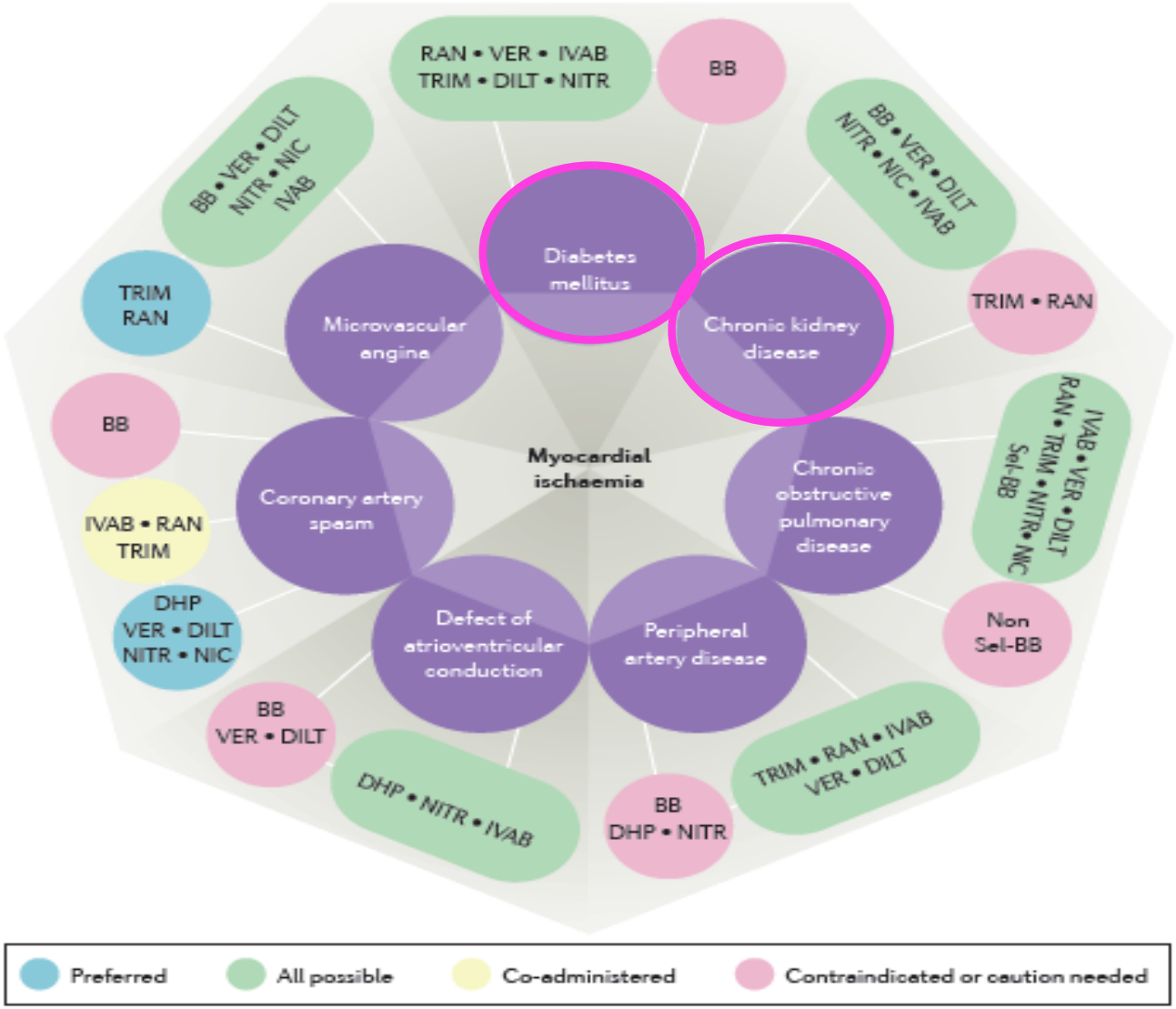

Home take messagge:

- Alla luce delle evidenze cliniche la terapia medica ottimale dovrebbe essere il fondamento nella gestione del paziente con angina stabile

- Terapia medica ottimale non vuol dire escludere la rivascolarizzazione a priori, piuttosto l'utilizzo di un approccio "intensivo" farmacologico e non farmacologico

- Avendo i farmaci antianginosi una simile efficacia non si possono classificare in farmaci di "prima" o "seconda" scelta. E' necessario quindi utilizzare un'approccio terapeutico "personalizzato" che tenga conto delle caratteristiche del paziente, delle sue comorbilità e dei meccanismi fisiopatologici alla base dell'ischemia miocardica.

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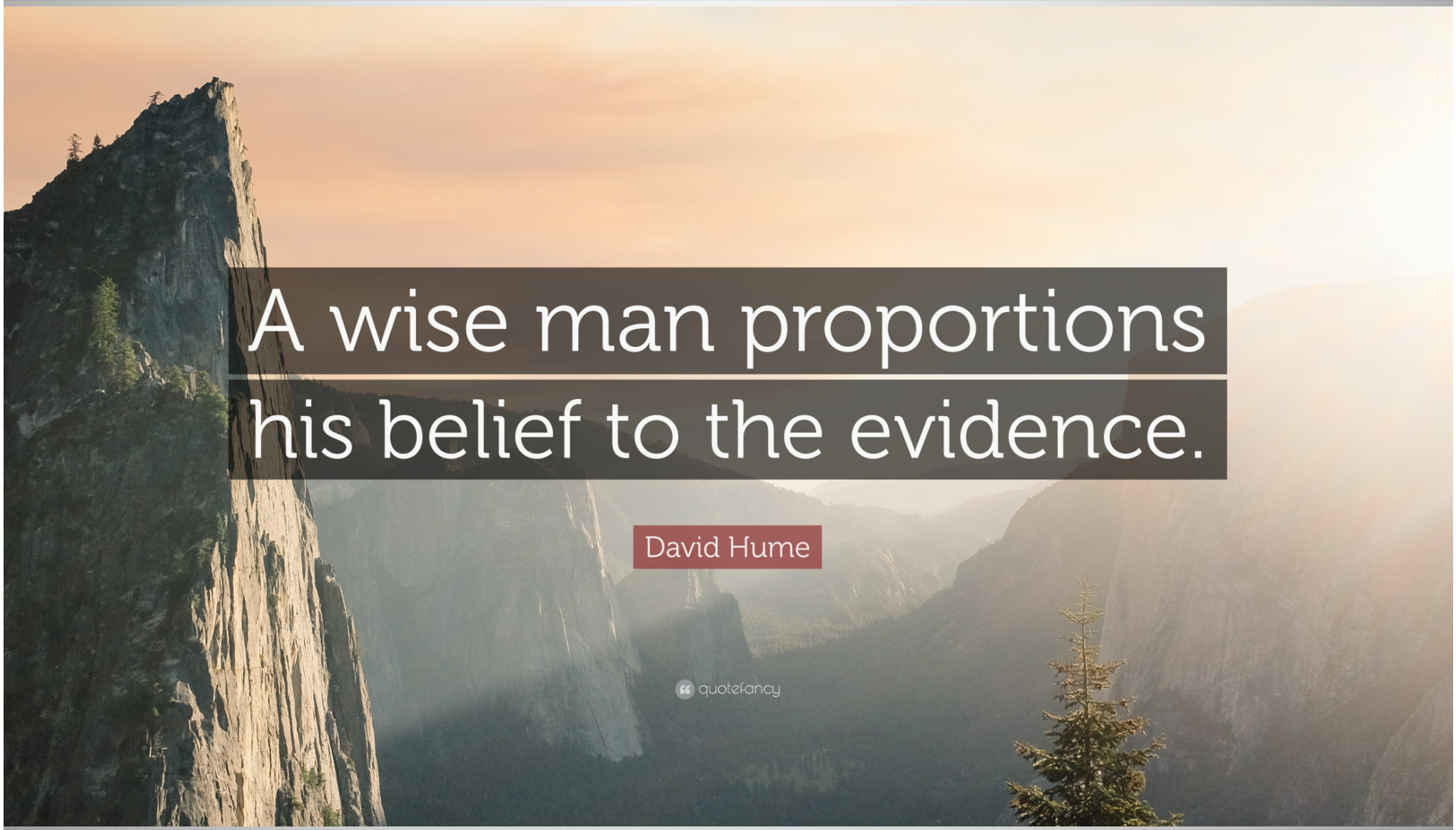

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