

# Different Continents / Different Guidelines ?



## ST-E & NSTEMI-ACS Guidelines



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# Disclosure

I declare not having a significant revenue  
from the industry



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# ACS: Different Continents / Different Guidelines ?

Question ?

How many more references does the STEMI American Guidelines have vs. the European?

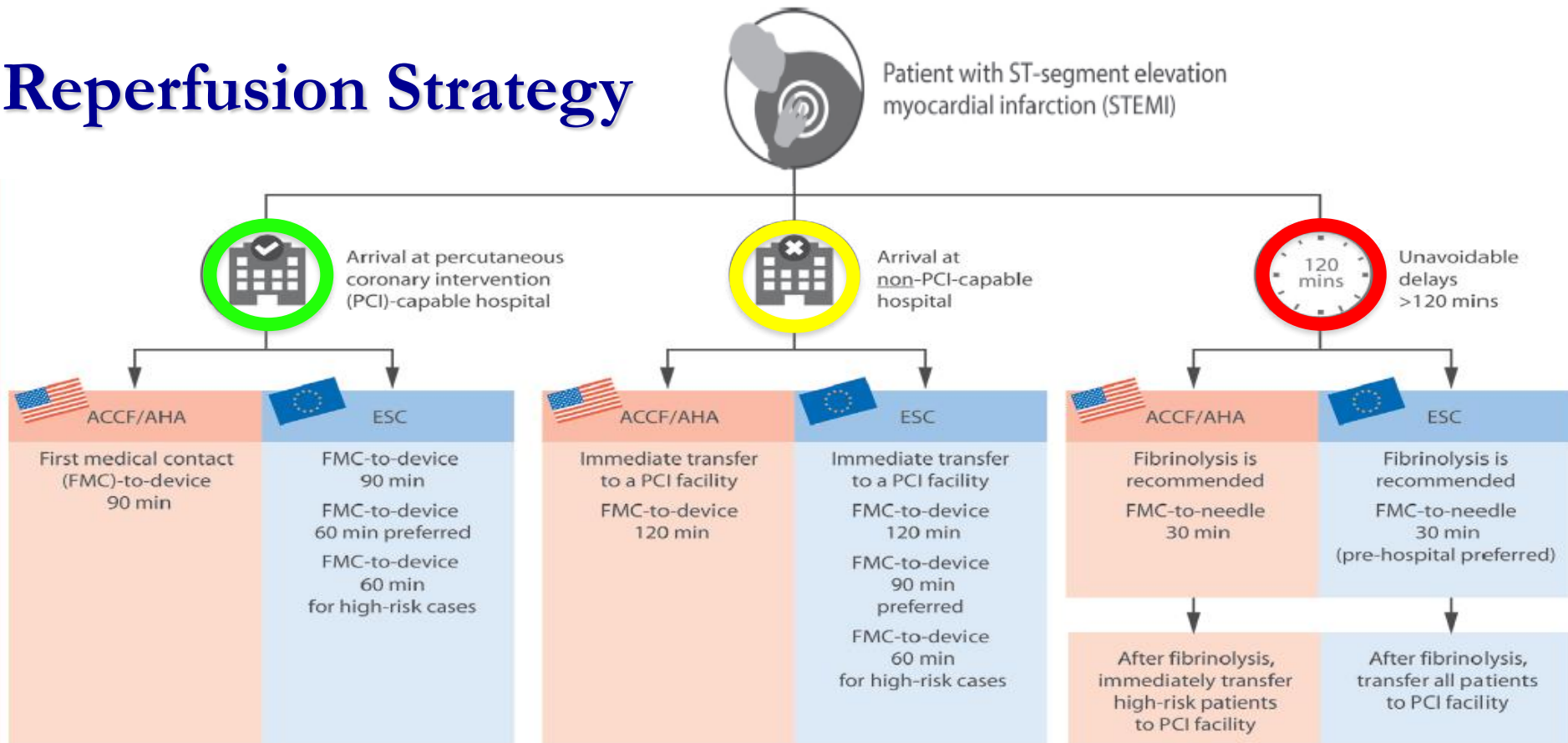
- a) 1000
- b) 500
- c) 300

A: ESC 2012 346 ref./ AHA-ACC 2013 656 ref.



Adherence GD's has  
been associated with  
improvements in  
patient outcomes

# Reperfusion Strategy



**Pharmacotherapy used in reperfusion****Primary PCI**

Aspirin	I-B	I-B
P2Y12-----	<b>I-B</b>	<b>I-A</b>
IIb/IIIa-----	<b>IIa-B</b>	<b>IIb-B</b>
Upstream IIb/IIIa	IIb-B	IIb-B
UFH	I-C	I-C
Bivalirudin over UFH + IIb/IIIa-----	<b>IIa-B</b>	<b>I-B</b>
Enoxaparin over UFH-----	<b>NA</b>	<b>IIb-B</b>
Fondaparinux	III-B	III-B

**Lithic Therapy**

Aspirin-----	<b>I-A</b>	<b>I-B</b>
Clopidogrel	I-A	I-A

**Anticoagulation up to 8 days or revascularization**

UFH	I-C	I-C
Enoxaparin	I-A	I-A
Fondaparinux-----	<b>I-B</b>	<b>IIa-B</b>



# More Differences

ACC/AHA		ESC
Severe HF and Cardiogenic Shock	Emergent Revasc. C IB	Equal CI B Less enthusiastic C-IIa-C C-IIb LOE B
Acute e HF & LVD	Limited Recommendations	Extensive Recommendations Diuretics & Inotropic meds
Hyperglycemia in STEMI	Maintained < 180 mg/dl	Extensive Recommendations
Logistics of Care	Early Discharge uncomplicated after 72 hrs	Selected Low Risk Pts
Secondary Prevention Aspirin/P2Y12	C-IIa LOE B One yr	No clear efficacy One yr Gastric protection
B Blockers	C I LOE B	C II a LOE A
IECA & Statins	C I LOE B	Diabetic status C I LOE A
Rivaroxaban LVEF < 40 % < 35 % w/ StS < 30 % no StS	No approved ICD IB Re-evaluation > 40 days ICD recommended	Approved Re-evaluation 3 Mo after

# Future Consideration

ACC/AHA		ESC
Early Presenters Stream Trial LT Superior vs PCI > 90 min	No recommendations	Euromax / Heat PCI ➤ Thrombosis risk ➤ > MACE ➤ No less bleed
Radial Access Matrix / Rifle	Limited Rec	Radial Preferences
Routine Full Revasc P-PCI NRA-IM	No Total definition	No Total Definition
Aspiration TMC Taste / Total	Aspiration TMC C IIIa LOE B to C III LOE A	same
Secondary Prevention Aspirin/P2Y12	C-IIa LOE B One yr	No clear efficacy One yr Gastric protection

# In Summary STE-ACS ACC/AHA vs. ESC Guidelines

- At present time there are reasons to keep separated ACC/AHA vs. ESC GDs
- Alignment on LOE is required (Atlantic network)
- Increasing costs exclude therapies in countries



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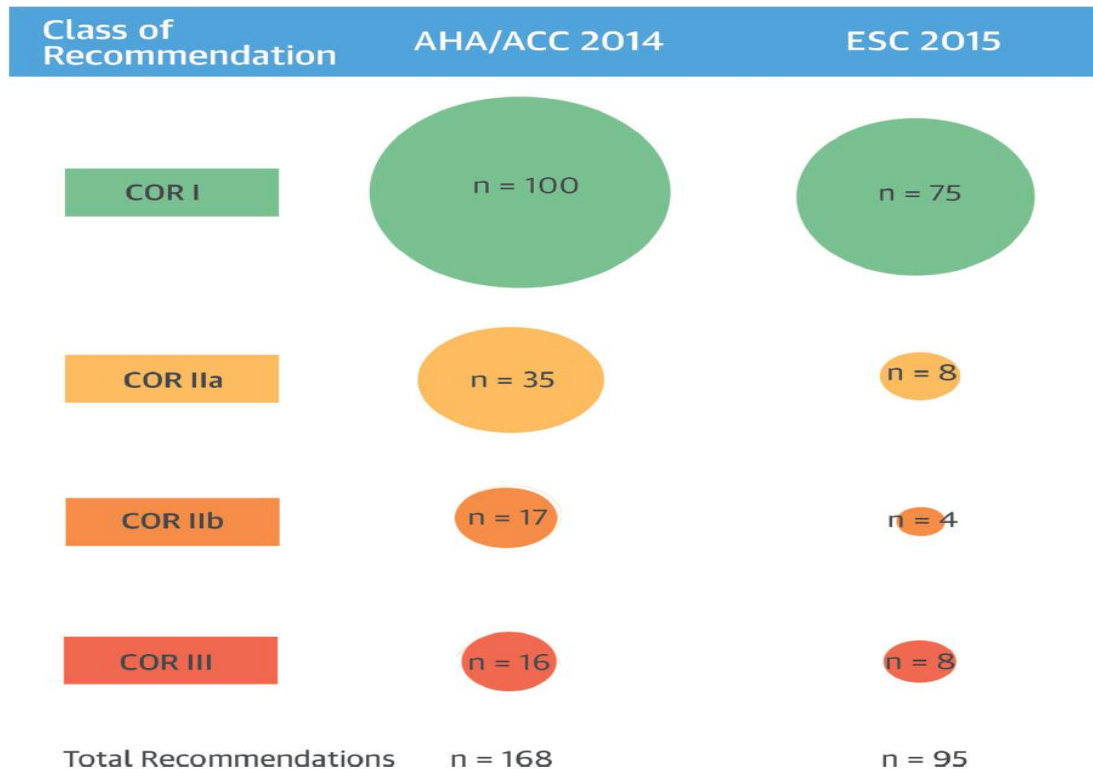


# Different Continents / Different Guidelines ?

## NSTE-ACS

Leading cause of  
m/m from CVD  
in worldwide

**CENTRAL ILLUSTRATION** Comparison of Frequency of Recommendations for NSTE-ACS Management According to AHA/ACC and ESC Guidelines by Class of Recommendation



# NSTEMI Anti-Platelet Therapy C-I

## AHA/ACC

- No enteric coated aspirin to all pts. 162-325 mg Id /81-325 indefinitely
- P2Y12 either Clopi/Tica for 12 Mo in all pts with NSTEMI
- In pts w/ HR features NO pre-treated w/ Clopi or Tica is usefull use 2B/3A inhibitor at PCI time

## ESC

- Aspirin for all pts. w/out contra/lx 150-300 mg Id /75-100 mg lomg term.
- P2Y12 Preferentially Tica from moderate to HR pts for 12 Mo. Unless contra/lx such as Risk bleed irrespective revascularization strategy



# NSTEMI Anti-Coagulant Therapy C-I

## AHA/ACC ESC

- SC Enoxaparin for the duration of hospitalization or until PCI is Performed
- Alternatives to Enoxaparin : Bivalirudin, Fondaparinux and HFH
- Fondaparinux is Recommended as First Line for NSTE-ACS management Strategy
- Bivalirudin as an alternative to UFH plus 2B/3A Inhibitors during PCI



# NSTEMI Strategy C-I AHA/ACC

- Early Invasive and ischemia-guided Strategies
- Urgent Immediate invasive strategy in pts. with refractory angina and hemodynamic or electrical instability

## ESC

- An early invasive strategy is indicate for pts. with HR fatures (<72 hrs)
- Radial over Femoral acces for coronary angiography and PCI
- In pts. undergoing PCI, new generation DES are recomended



# Future

- Updates every 2-5 years
- Mini updates every year

## Conclusions:

- Both Guidelines are comprehensive reviews of available evidence



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# “Guidemaniacs”

## Revista Mexicana de Cardiología 27:(1) march 2016

- EGs/AGs may not be suitable for Countries like MEXICO
- We are different **genetically and have a environment**
- Our challenge is to unify to make our own guidelines
- The “elite” that governs us is on a deep coma and apathy
- AGs/EGs correct or not, valid or not, they write his own history because many data base

*Eduardo Meany MD PhD*



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# Thank you !!



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