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ÚNICA EXPERIENCIA EDUCACIONAL EN TU ÁREA

Evolving Concepts in Non-ST Elevation ACS (NSTE-ACS)

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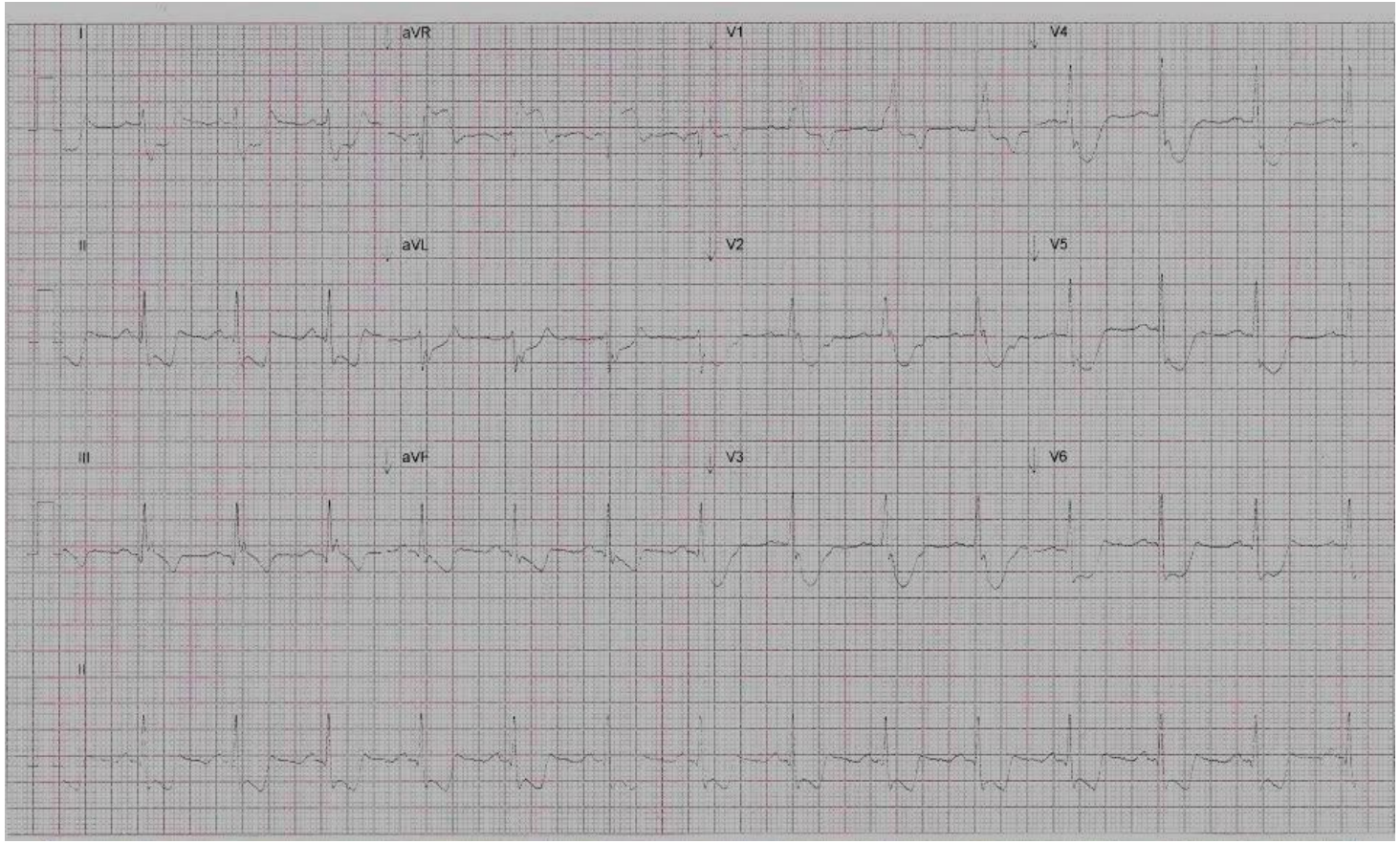
ACC Latin America Conference 2016

Case presentation

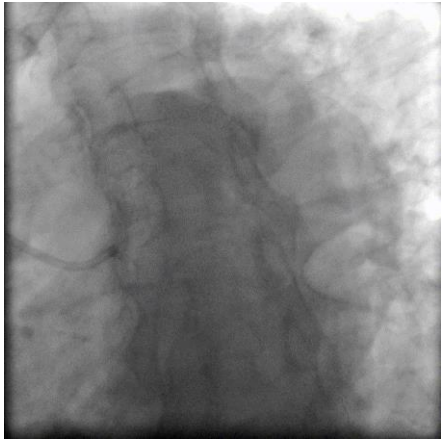
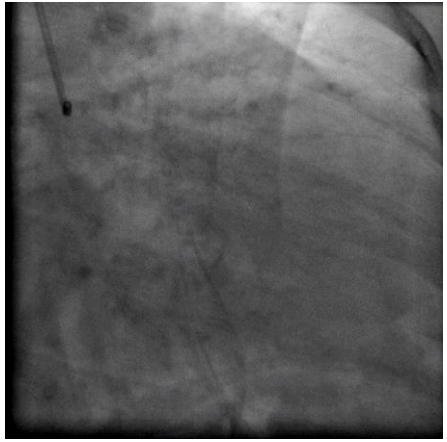
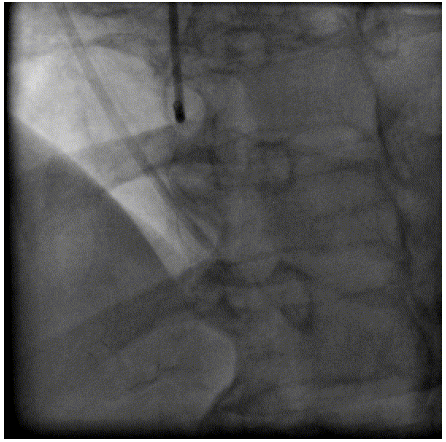
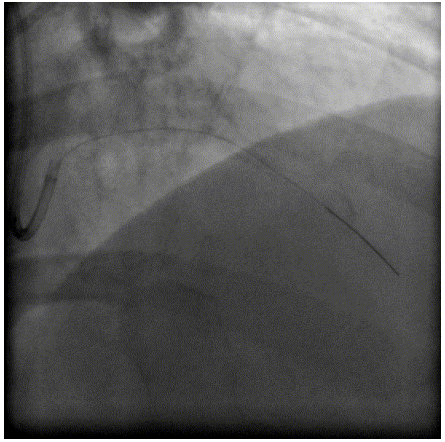
- 61 years old female, HTN and dyslipidemia
- Chest pain 2 hours ago while being in rest
- No HF at presentation with normal cardiac biomarkers and RBBB on ECG
- UA, GRACE 88, TIMI 1, CRUSADE 38

Treatment

- ASA: 300 mg loading dose
- Clopidogrel: 300 mg loading dose
- Isosorbide dinitrate: 5 mg SL
- Atorvastatin: 80 mg
- Enalapril: 10 mg bid
- Unfractioned heparin: 60U/Kg loading dose, 12U/Kg/hr infusion

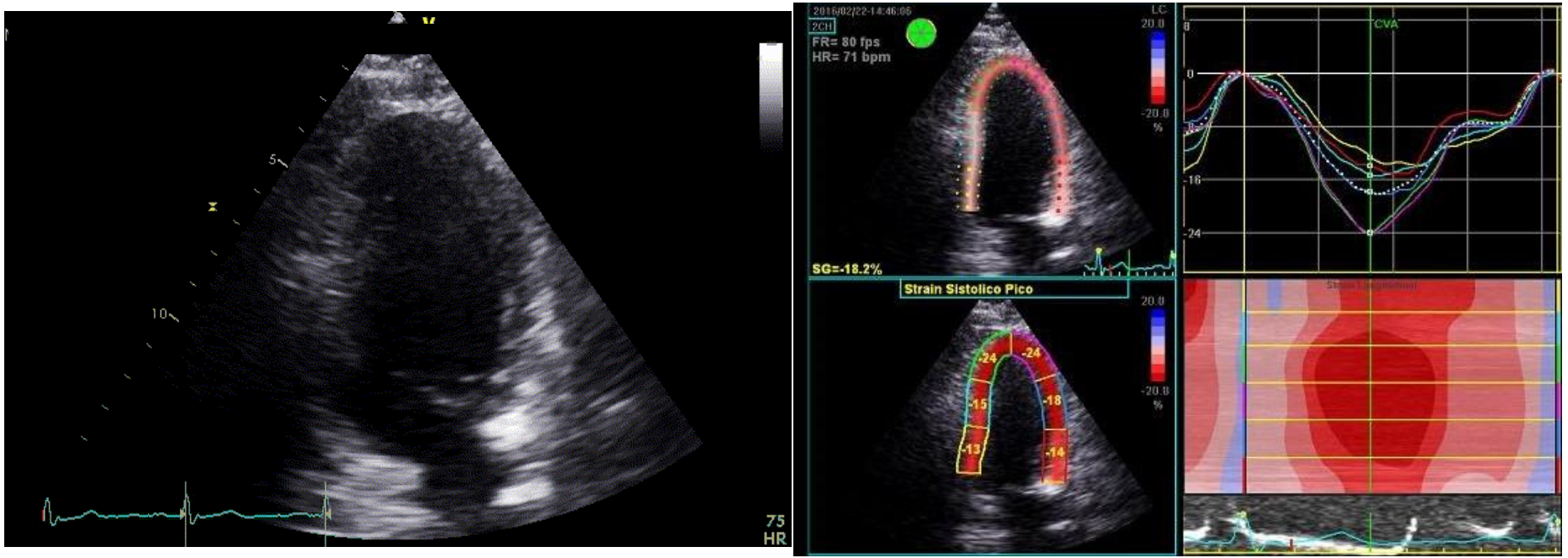

I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II

Coronarography

» Syntax 31

Echocardiography



Treatment

- Surgery:
  - IMA to LDA
  - LRA to first OM
  - ISV to first diagonal
  - ISV to PD

Recommendations	Dosing and Special Considerations	COR	LOE	References
Aspirin				
• Non-enteric-coated aspirin to *all* patients promptly after presentation	162 mg–325 mg	I	A	(288–290)
• Aspirin maintenance dose continued indefinitely	81 mg/d–325 mg/d*	I	A	(288–290, 293,391)
$P2Y_{12}$ inhibitors				
• Clopidogrel loading dose followed by daily maintenance dose in patients unable to take aspirin	75 mg	I	B	(291)
• $P2Y_{12}$ inhibitor, in addition to aspirin, for up to 12 mo for patients treated initially with either an early invasive or initial ischemia-guided strategy: – Clopidogrel – Ticagrelor*	300-mg or 600-mg loading dose, then 75 mg/d 180-mg loading dose, then 90 mg BID	I	B	(289,292) (293,294)
• $P2Y_{12}$ inhibitor therapy (clopidogrel, prasugrel, or ticagrelor) continued for at least 12 mo in post-PCI patients treated with coronary stents	N/A	I	B	(293,296,302, 330,331)
• Ticagrelor in preference to clopidogrel for patients treated with an early invasive or ischemia-guided strategy	N/A	IIa	B	(293,294)

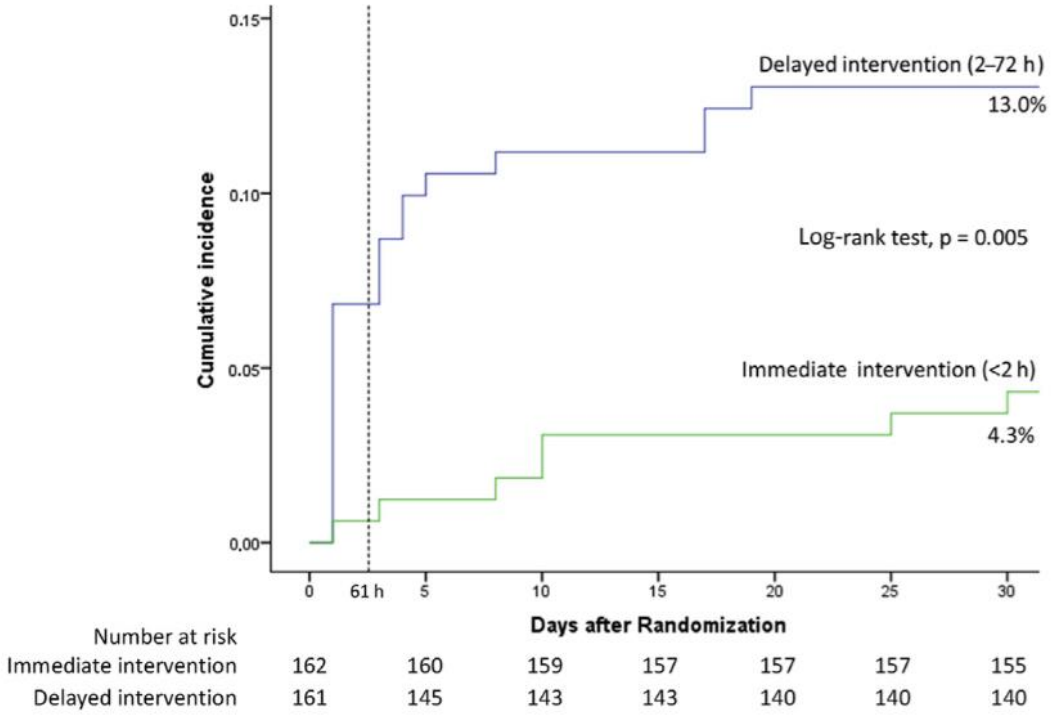
2014 AHA/ACC Guideline for the Management of Patients With Non-ST Elevation Acute Coronary Syndromes

Parenteral anticoagulant and fibrinolytic therapy				
• SC enoxaparin for duration of hospitalization or until PCI is performed	• 1 mg/kg SC every 12 h (reduce dose to 1 mg/kg/d SC in patients with CrCl <30 mL/min) • Initial 30 mg IV loading dose in selected patients	I	A	(133,136,309)
• Bivalirudin until diagnostic angiography or PCI is performed in patients with early invasive strategy only	• Loading dose 0.10 mg/kg loading dose followed by 0.25 mg/kg/h • Only provisional use of GP IIb/IIIa inhibitor in patients also treated with DAPT	I	B	(292,293, 310,311)
• SC fondaparinux for the duration of hospitalization or until PCI is performed	2.5 mg SC daily	I	B	(312–314)
• Administer additional anticoagulant with anti-IIa activity if PCI is performed while patient is on fondaparinux	N/A	I	B	(313–315)
• IV UFH for 48 h or until PCI is performed	• Initial loading dose 60 IU/kg (max 4,000 IU) with initial infusion 12 IU/kg/h (max 1,000 IU/ h) • Adjusted to therapeutic aPTT range	I	B	(316–322)
• IV fibrinolytic treatment not recommended in patients with NSTE-ACS	N/A	III: Harm	A	(93,329)

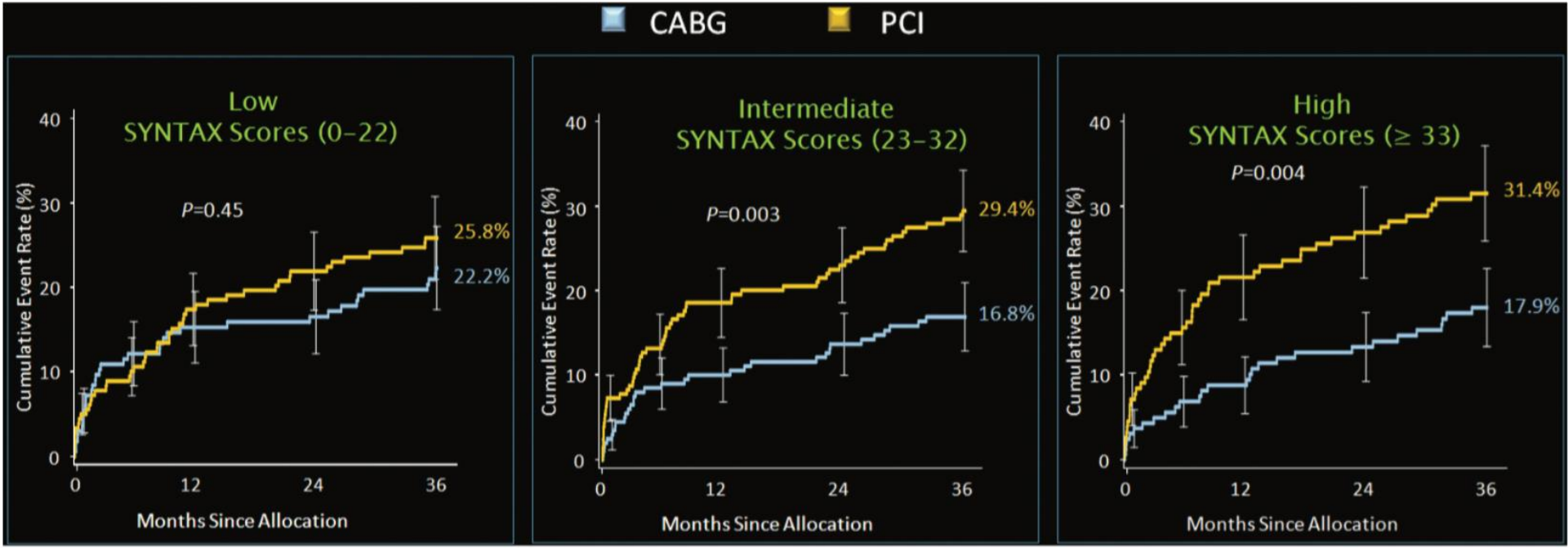
2014 AHA/ACC Guideline for the Management of Patients With Non-ST Elevation Acute Coronary Syndromes

Immediate invasive (within 2 h)	Refractory angina
	Signs or symptoms of HF or new or worsening mitral regurgitation
	Hemodynamic instability
	Recurrent angina or ischemia at rest or with low-level activities despite intensive medical therapy
	Sustained VT or VF
Ischemia-guided strategy	Low-risk score (e.g., TIMI [0 or 1], GRACE [<109]) Low-risk Tn-negative female patients
	Patient or clinician preference in the absence of high-risk features
Early invasive (within 24 h)	None of the above, but GRACE risk score >140 Temporal change in Tn (Section 3.4)
	New or presumably new ST depression
Delayed invasive (within 25–72 h)	None of the above but diabetes mellitus Renal insufficiency (GFR <60 mL/min/1.73 m^2)
	Reduced LV systolic function (EF <0.40)
	Early postinfarction angina
	PCI within 6 mo
	Prior CABG
	GRACE risk score 109–140; TIMI score ≥2

2014 AHA/ACC Guideline for the Management of Patients With Non-ST Elevation Acute Coronary Syndromes



Milosevic A, et al. Inmediate versus delayed invasive intervention for non STEMI patients. The RIDDLE NSTEMI styudy. JACC cardiovascular interventions, 2016



2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery

Recommendation for Duration of DAPT in Patients With ACS Treated With CABG

COR	LOE	RECOMMENDATION
I	C-LD	In patients with ACS being treated with DAPT who undergo CABG, $P2Y_{12}$ inhibitor therapy should be resumed after CABG to complete 12 months of DAPT therapy after ACS (52-54,118-120).

2016 ACC/AHA Guideline Focused Update ond Duration of Dual Antiplatelet Therapy in Patients With Coronary Artery Disease

Conclusions

- Patients with NSTE ACS have an increase risk of 3VD
- Sequential EKG and day by day risk stratification improves the identification of patients with higher risk
- Balloon angioplasty is an alternative treatment as a bridge for surgery