

**RESURCOR**  
**Jeudi 09 Décembre 2021**

# **Actualités SCA 2020-2021**

# SCA non ST+



**ESC**

European Society  
of Cardiology

European Heart Journal (2020) **00**, 1–79  
doi:10.1093/eurheartj/ehaa575

**ESC GUIDELINES**

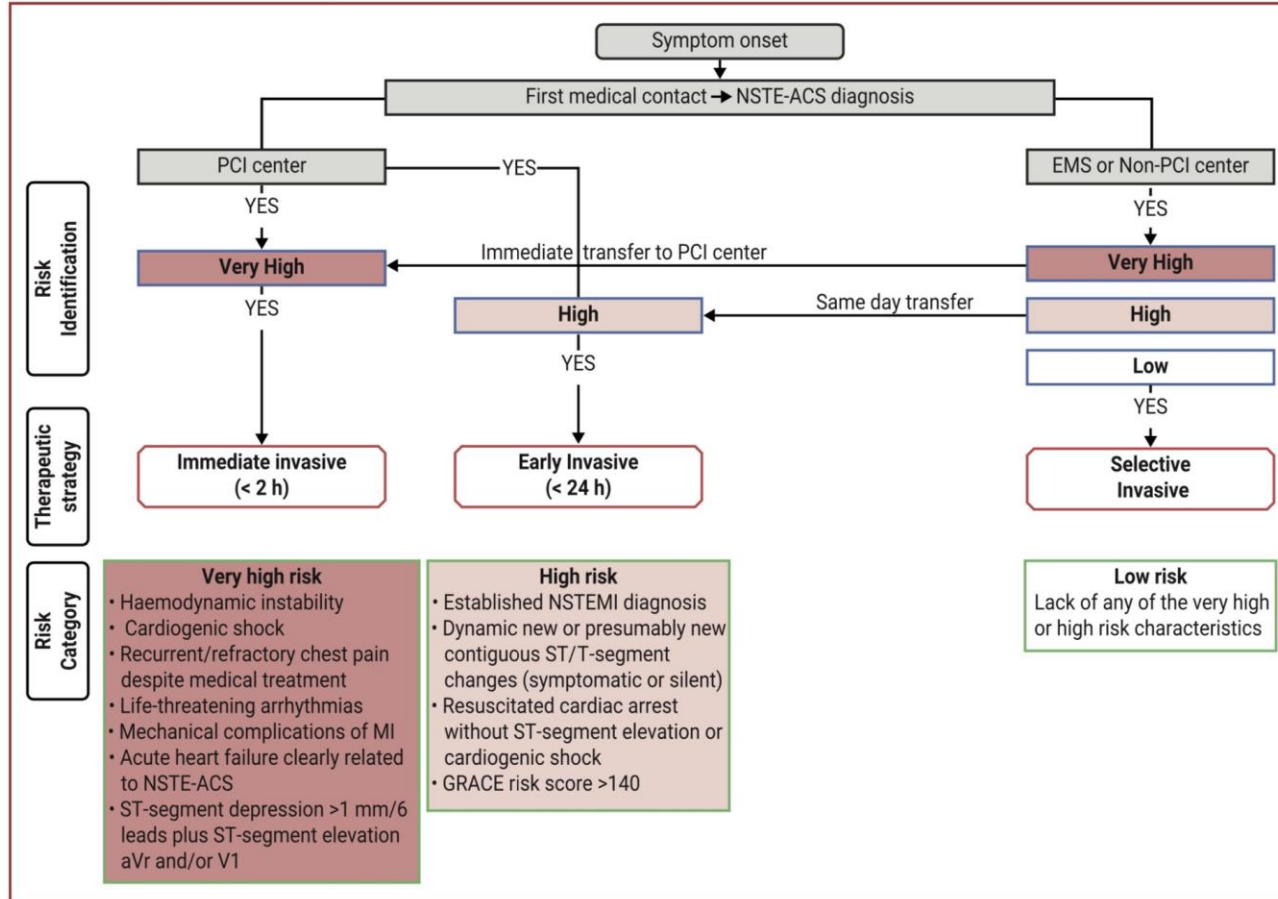
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## **2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation**

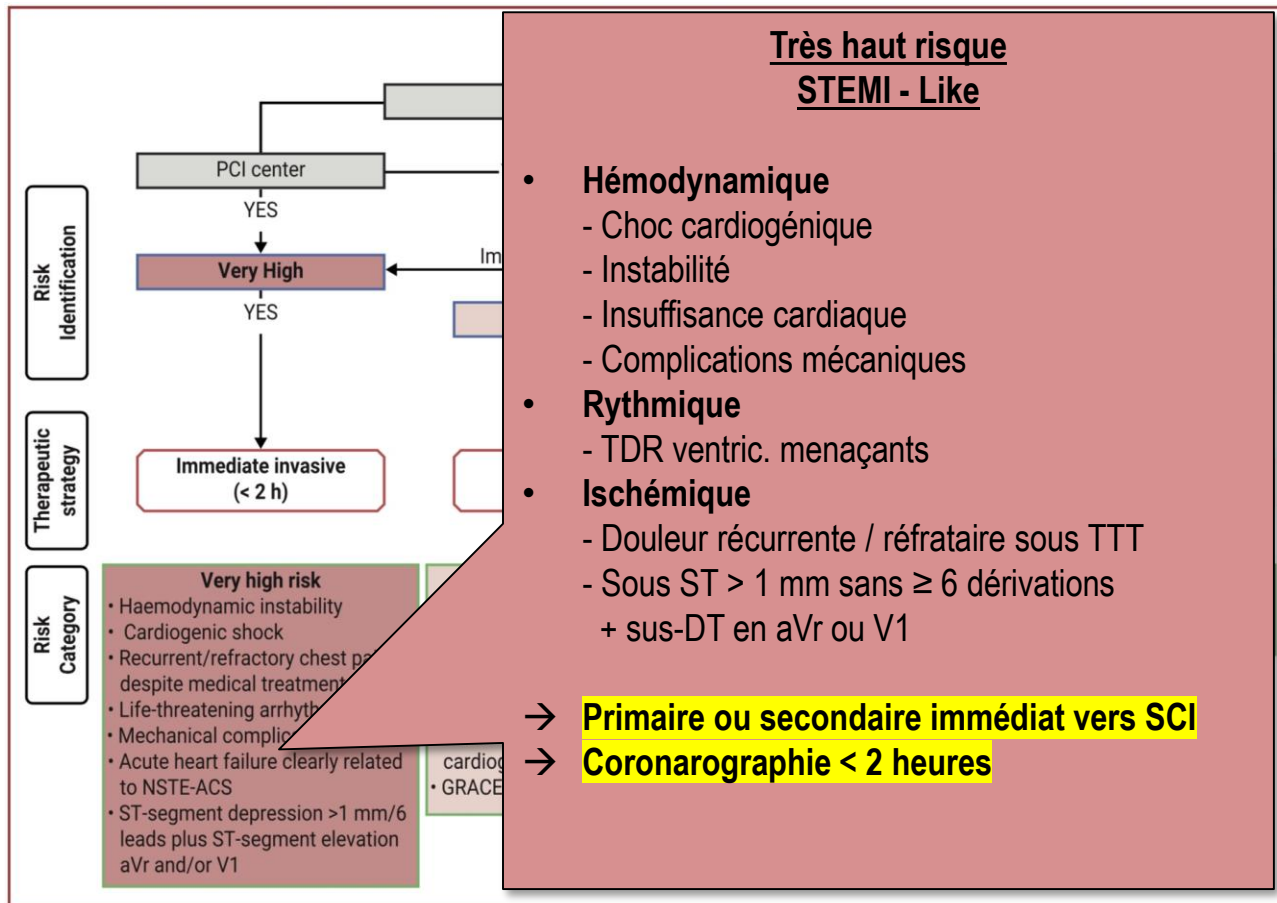
**The Task Force for the management of acute coronary syndromes  
in patients presenting without persistent ST-segment elevation of  
the European Society of Cardiology (ESC)**

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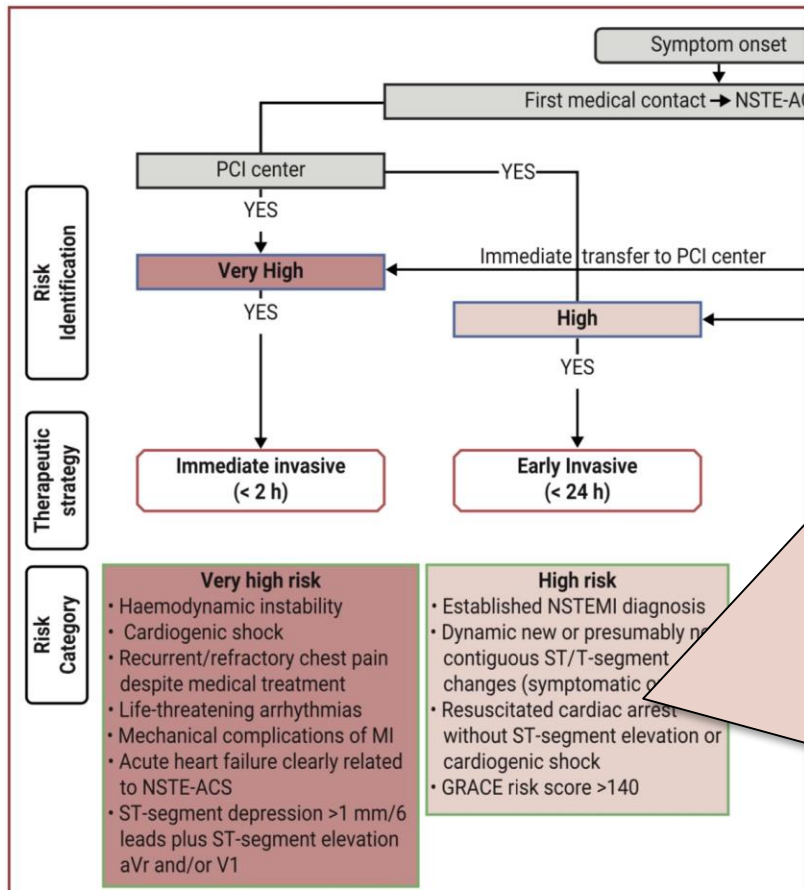
# Timing de la coronarographie



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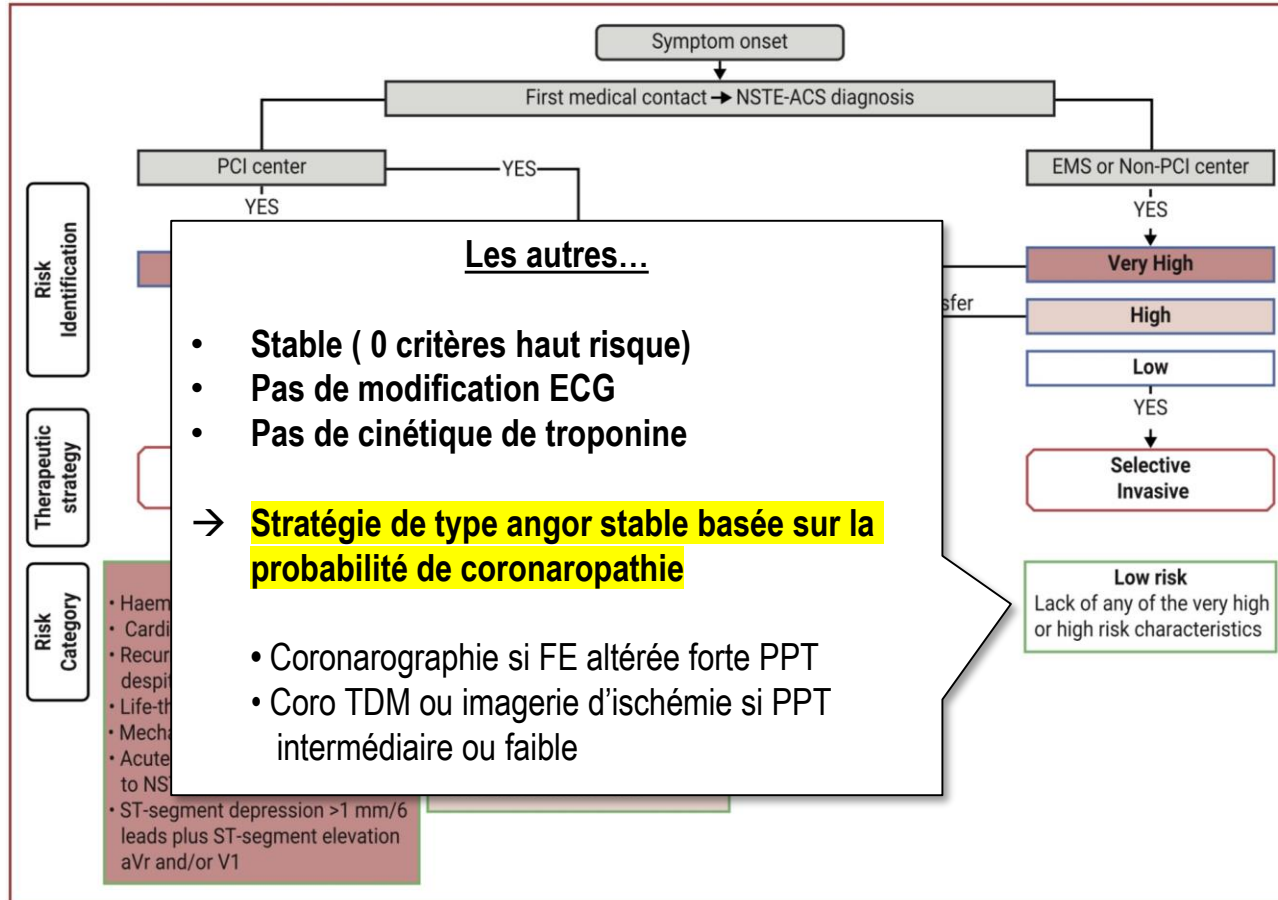
## Haut risque STEMI - Like

- **NSTEMI**
  - Cinétique de troponie
- **ECG**
  - Modification ST/T
  - De novo ou dynamique
  - Symptomatique ou non
- **GRACE > 140**
- **Post-ACR sans ST+ ni choc**

→ **Secondaire dans la journée vers CCI**

→ **Coronarographie < 24 heures**

# Timing de la coronarographie



# La fin du prétraitement par les inhibiteurs de P2Y12

**CREDO**

2005

Pré TTT Clopidogrel  
> Placebo

**TRITON**

**PLATO**

2009

Nouveaux P2Y12  
> Clopidogrel

**ACCOAST**

2013

Prasugrel pré < post-TTT

**ISAR REACT 5**

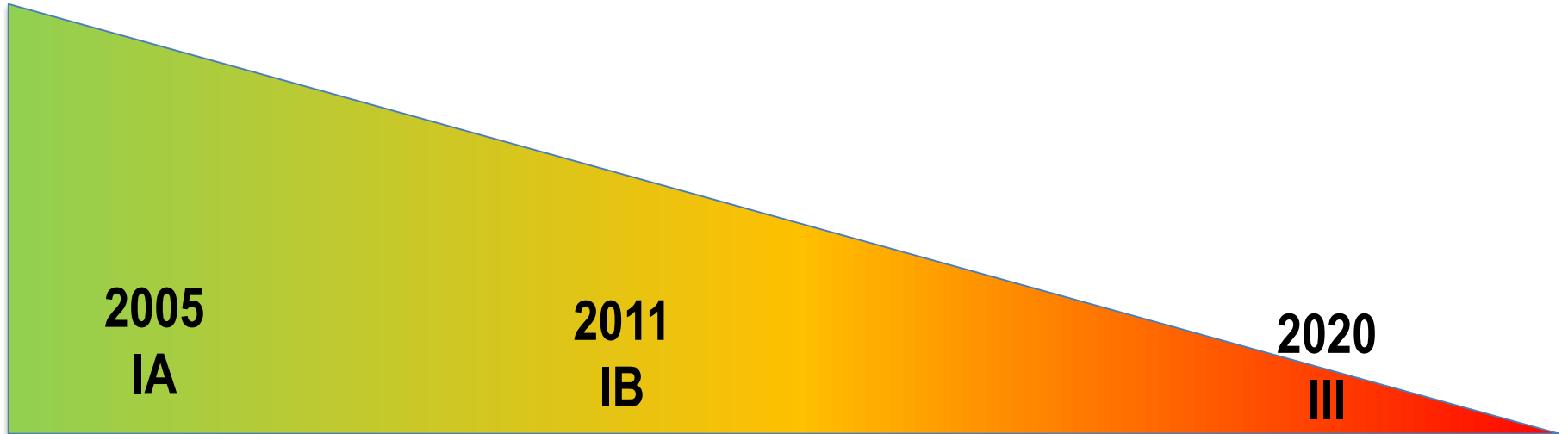
2019

Stratégie Prasugrel  
> Stratégie Ticagrelor

**2005**  
**IA**

**2011**  
**IB**

**2020**  
**III**



# ISAR REACT 5

## Unstable Angina, NSTEMI

### Randomization

**Ticagrelor**  
180 mg loading

### Angiography

**Prasugrel**  
60 mg loading

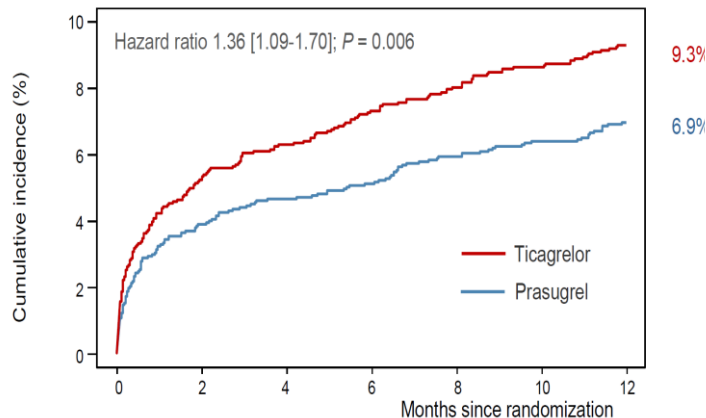
### PCI

**Ticagrelor**  
90 mg 1-0-1

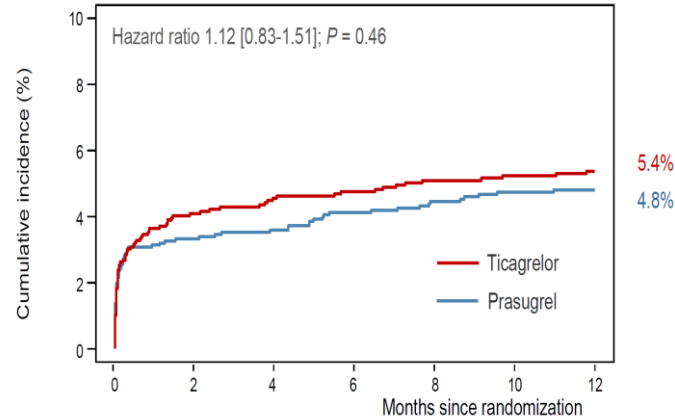
**Prasugrel**  
10 mg 1-0-0\*

NEJM 2019;381:1524

### Critère d'efficacité (+ - IDM – AVC)



### Critère de sécurité (BARC 3-5 bleedings)

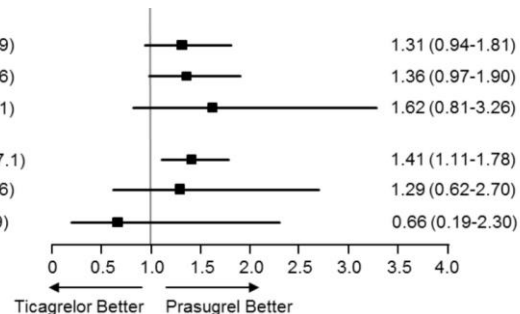


### Clinical Presentation

STEMI	83/833 (10.1)	64/820 (7.9)
NSTEMI	81/930 (8.8)	60/925 (6.6)
Unstable Angina	20/249 (8.2)	13/261 (5.1)

### Treatment Strategy

PCI	162/1676 (9.8)	120/1701 (7.1)
Conservative	17/285 (6.1)	12/268 (4.6)
CABG	5/47 (10.6)	5/36 (13.9)



# AAP dans le SCA non ST+

## Antiplatelet treatment

Aspirin is recommended for all patients without contraindications at an initial oral LD of 150–300 mg (or 75–250 mg i.v.), and at a MD of 75–100 mg o.d. for long-term treatment.<sup>179–181</sup>

I

A

A P2Y<sub>12</sub> receptor inhibitor is recommended in addition to aspirin, and maintained over 12 months unless there are contraindications or an excessive risk of bleeding.<sup>170,171,182</sup>

I

A

Options are:

- Prasugrel in P2Y<sub>12</sub> receptor inhibitor-naïve patients proceeding to PCI (60 mg LD, 10 mg/d as standard dose, 5 mg/d for patients aged ≥75 years or with a body weight <60 kg).<sup>171</sup>

I

B

- Ticagrelor irrespective of the planned treatment strategy (invasive or conservative) (180 mg LD, 90 mg b.i.d.).<sup>170</sup>

I

B

- Clopidogrel (300–600 mg LD, 75 mg daily dose), only when prasugrel or ticagrelor are not available, cannot be tolerated, or are contraindicated.<sup>182,183</sup>

I

C

Prasugrel should be considered in preference to ticagrelor for NSTEMI-ACS patients who proceed to PCI.<sup>174</sup>

IIa

B

GP IIb/IIIa antagonists should be considered for bail-out if there is evidence of no-reflow or a thrombotic complication.

IIa

C

Cangrelor may be considered in P2Y<sub>12</sub> receptor inhibitor-naïve patients undergoing PCI.<sup>184–187</sup>

IIb

A

Pre-treatment with a P2Y<sub>12</sub> receptor inhibitor may be considered in patients with NSTEMI-ACS who are not planned to undergo an early invasive strategy and do not have an HBR.

IIb

C

Treatment with GP IIb/IIIa antagonists in patients in whom coronary anatomy is not known is not recommended.<sup>188,189</sup>

III

A

It is not recommended to administer routine pre-treatment with a P2Y<sub>12</sub> receptor inhibitor in patients in whom coronary anatomy is not known and an early invasive management is planned.<sup>174,177,178,190,191</sup>

III

A



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European Heart Journal (2021) 42, 2973–2985  
doi:10.1093/eurheartj/ehab277

DEBATE

Clinical trials

**Debate: Prasugrel rather than ticagrelor is the preferred treatment for NSTEMI-ACS patients who proceed to PCI and pretreatment should not be performed in patients planned for an early invasive strategy**

Time to coronary angiography

Approximately 1 h in the ticagrelor arm

Short period of pre-treatment does not reflect the practice in many centres and countries where NSTEMI-ACS patients need to wait longer for coronary angiography and suggests that the results of ISAR-REACT-5 cannot be generalized to such centres

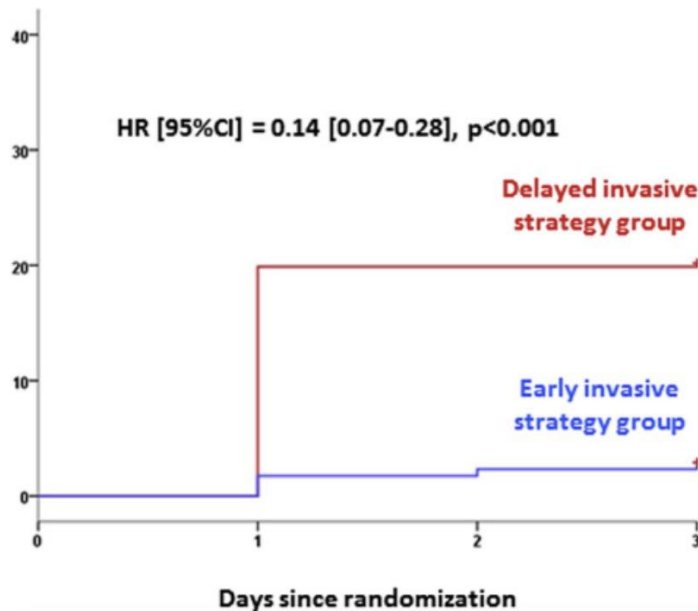
# Optimal Timing of Intervention in NSTEMI-ACS Without Pre-Treatment



## The EARLY Randomized Trial

Gilles Lemesle, MD, PhD,<sup>a,b,c,d</sup> Marc Laine, MD,<sup>e,f,g</sup> Mathieu Pankert, MD,<sup>h</sup> Ziad Boueri, MD,<sup>i</sup> Pascal Motreff, MD, PhD,<sup>j</sup> Franck Paganelli, MD,<sup>e,f,g</sup> Karine Baumstarck, MD, PhD,<sup>k</sup> Antoine Roch, MD, PhD,<sup>l,m</sup> François Kerbaul, MD, PhD,<sup>n</sup> Etienne Puymirat, MD, PhD,<sup>o,p</sup> Laurent Bonello, MD, PhD<sup>e,f,g</sup>

Rate (%) of primary endpoint (CV death and recurrent ischemic events)

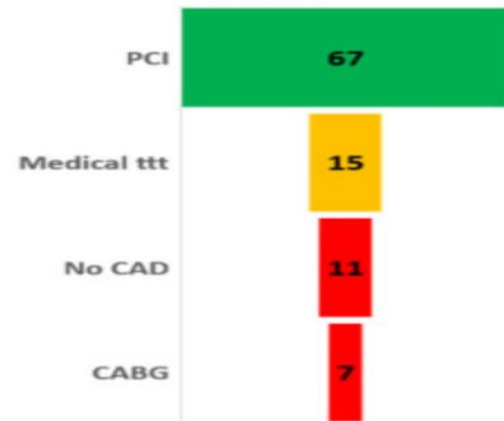


### Pré-traitement par Ticagrelor si

- Δc de SCA non ST+ certain
- Coronarographie > (12) 24 h
- Risque hémorragique bas
- Faible probabilité de CABG

- FONDAPARINUX : 2,5 mg/j SC.
- La Coronarographie devra être réalisée dans les 48 h.
  - Si elle est au mieux réalisée dans les 12 premières heures, ne pas donner d'autre AAP\*\*
  - Si elle est réalisée après la 12<sup>ème</sup> heure, TICAGRELOR 180 mg PO

### Management Strategy (%) in NSTEMI



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A

# SCA ST+



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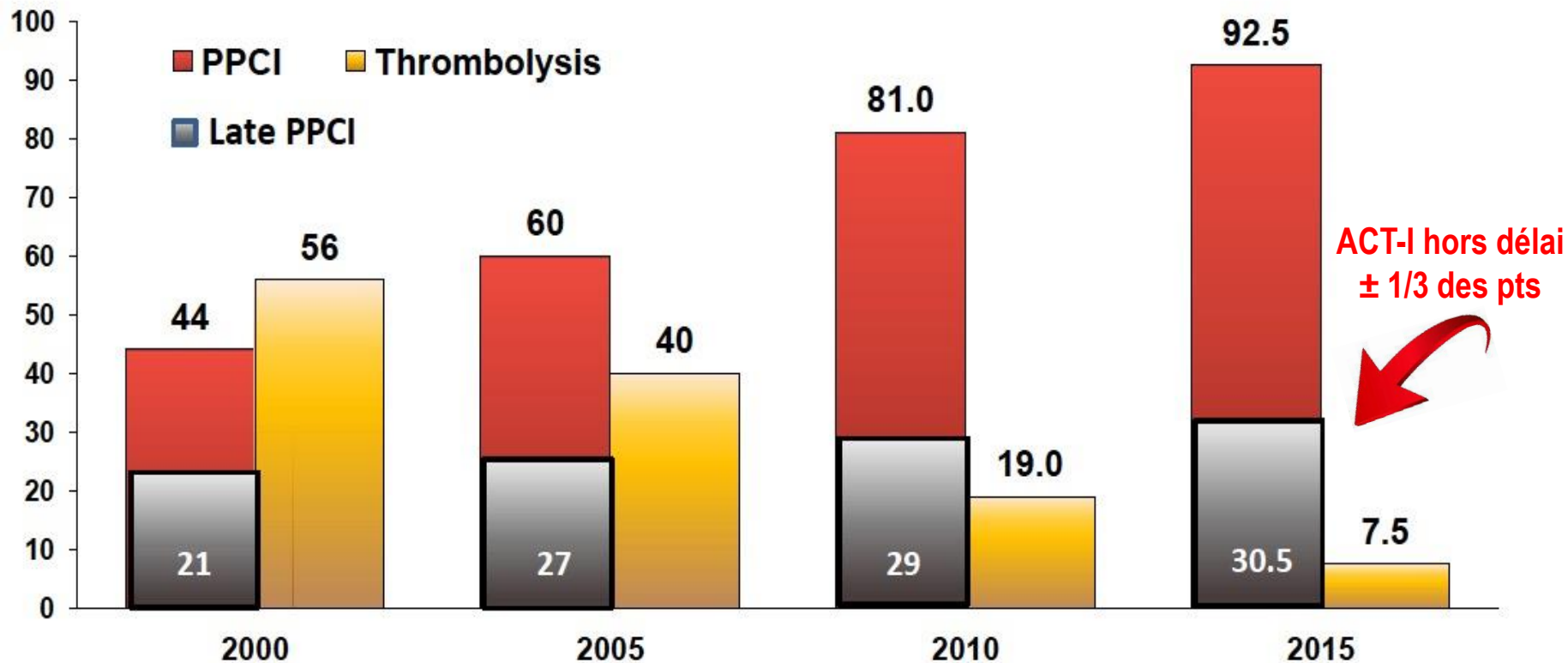
European Heart Journal (2017) **00**, 1–66  
doi:10.1093/eurheartj/ehx393

**ESC GUIDELINES**

## **2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation**

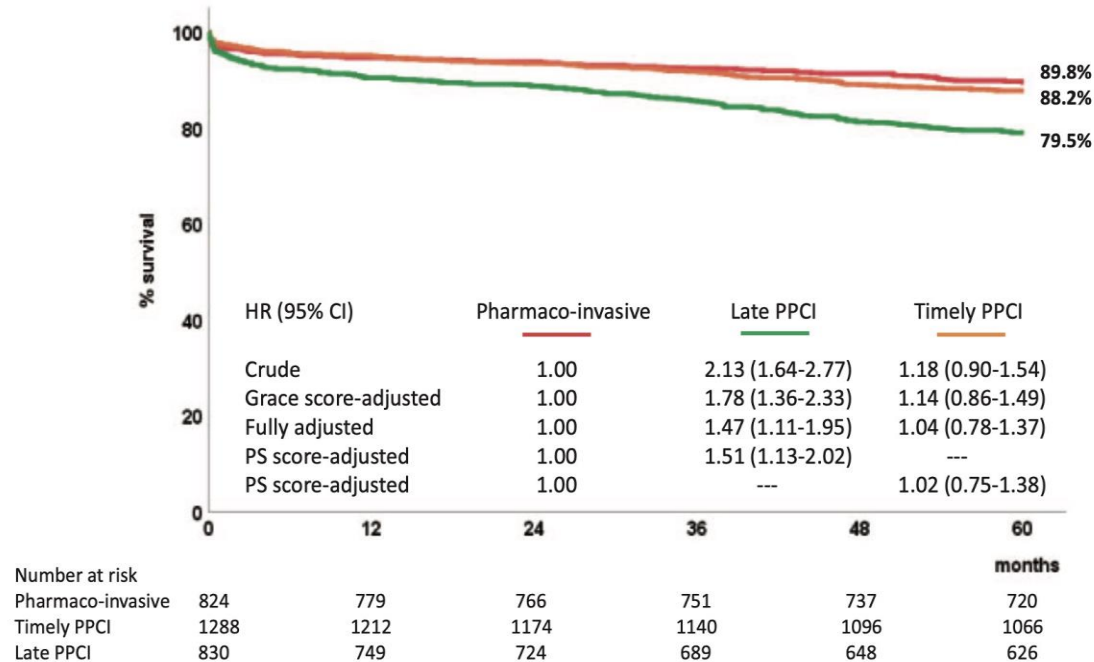
**The Task Force for the management of acute myocardial infarction  
in patients presenting with ST-segment elevation of the European  
Society of Cardiology (ESC)**

# FAST-MI : Evolution des méthodes de reperfusion

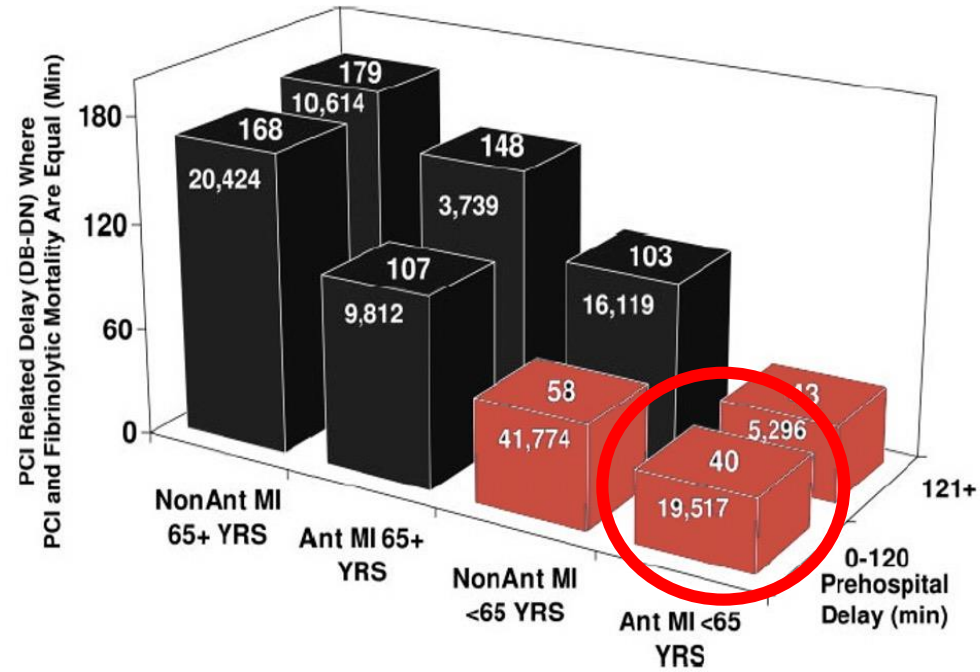
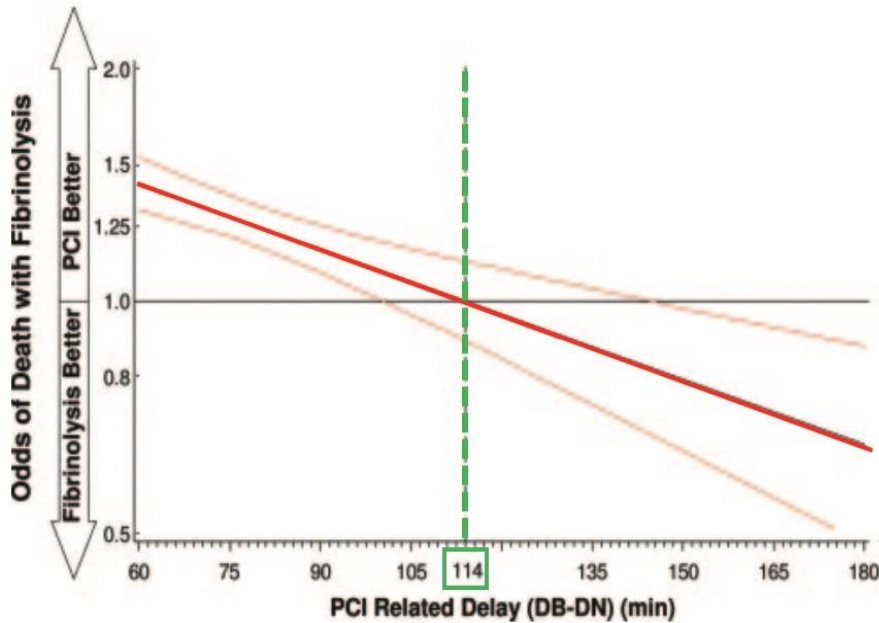


# Impact d'une ACT primaire hors délai

- 2942 patients avec diagnostic STEMI < 12h :
- 72% avec stratégie angioplastie primaire
  - Dont **28% d'angioplastie primaire « hors délai »** (>120min après diagnostic)
- 28% avec stratégie pharmaco-invasive



# 120 minute pour tous les STEMI ?



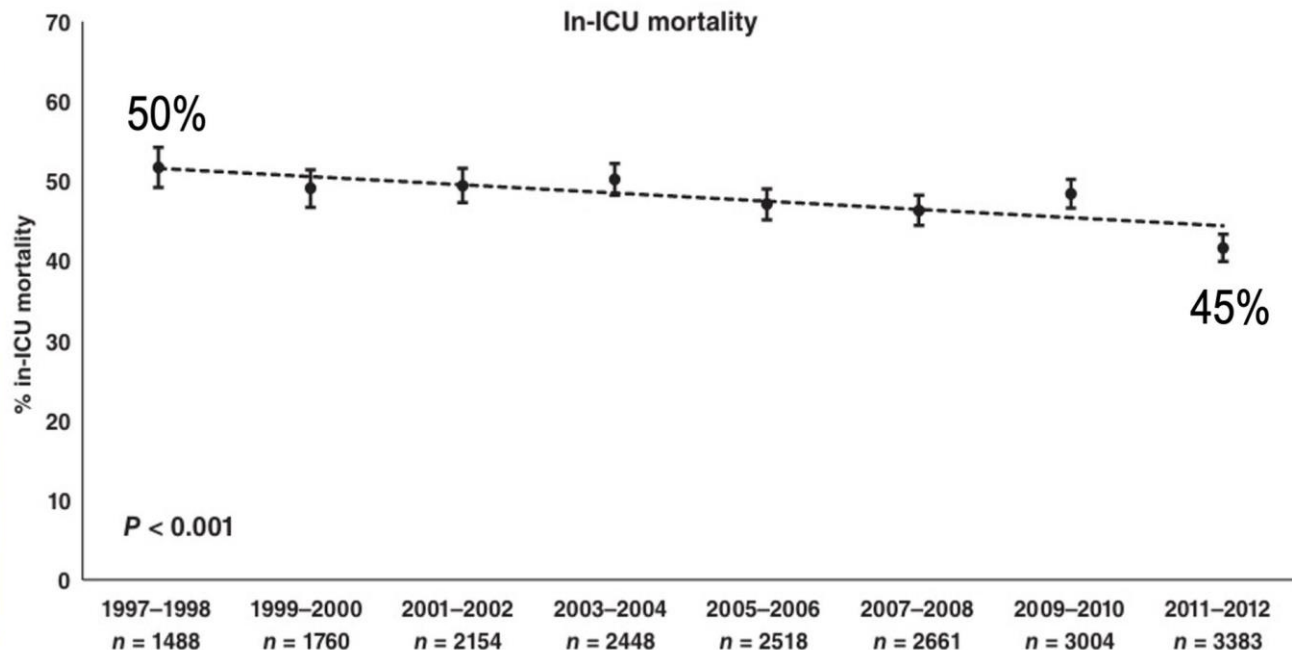
# Stratégie RESURCOR

<b>Délais début de douleur</b> <b>Délai porte-porte*</b>	<b>&lt; 3h</b>	<b>3h à 12h</b>
<b>&lt; 60 min</b>	<b>ANGIOPLASTIE</b>	<b>ANGIOPLASTIE</b>
<b>≥ 60 min</b> (ou doute sur précision du délai)	<b>THROMBOLYSE</b>	<b>ANGIOPLASTIE**</b>

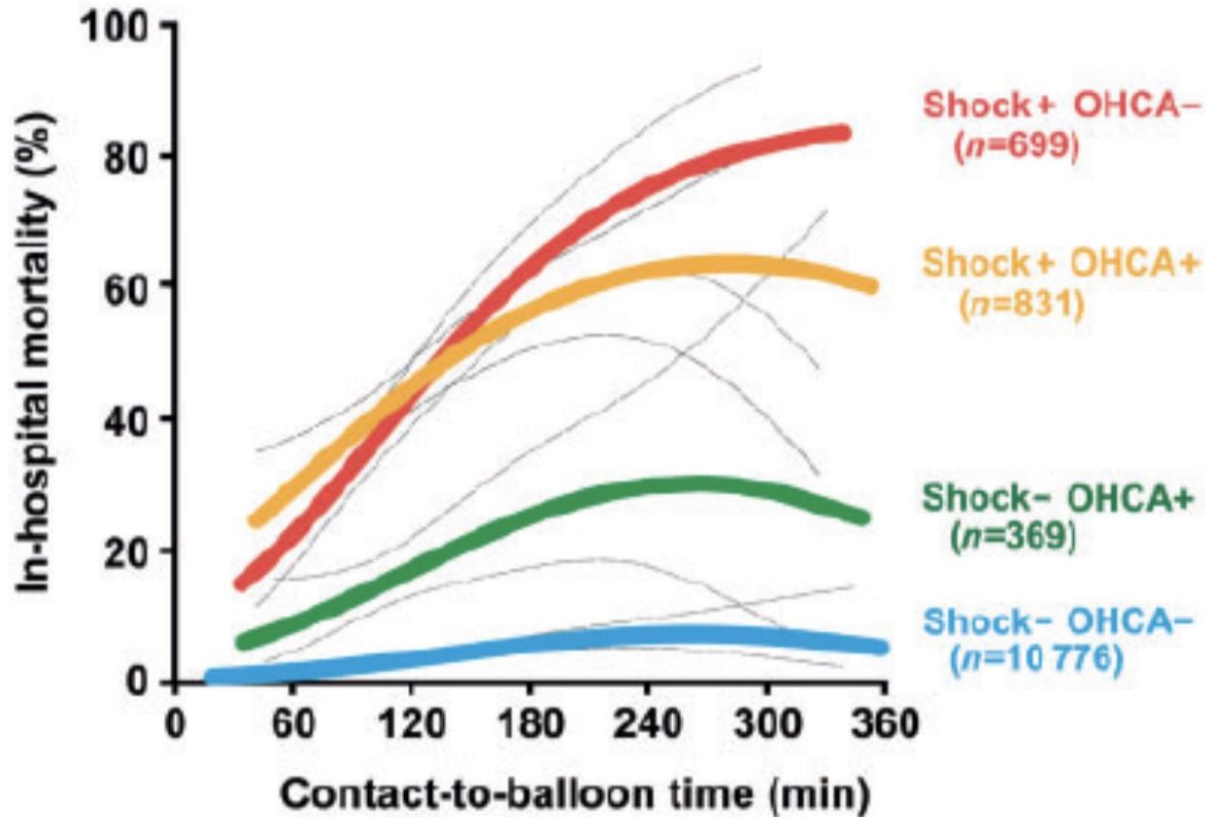
\* Délai porte-porte = délai entre le diagnostic par le médecin pouvant thrombolyser et l'arrivée devant la salle de cardiologie interventionnelle.

\*\* Envisager une fibrinolyse pour les patients très éloignés des salles de cardiologie interventionnelle, avec des infarctus larges.

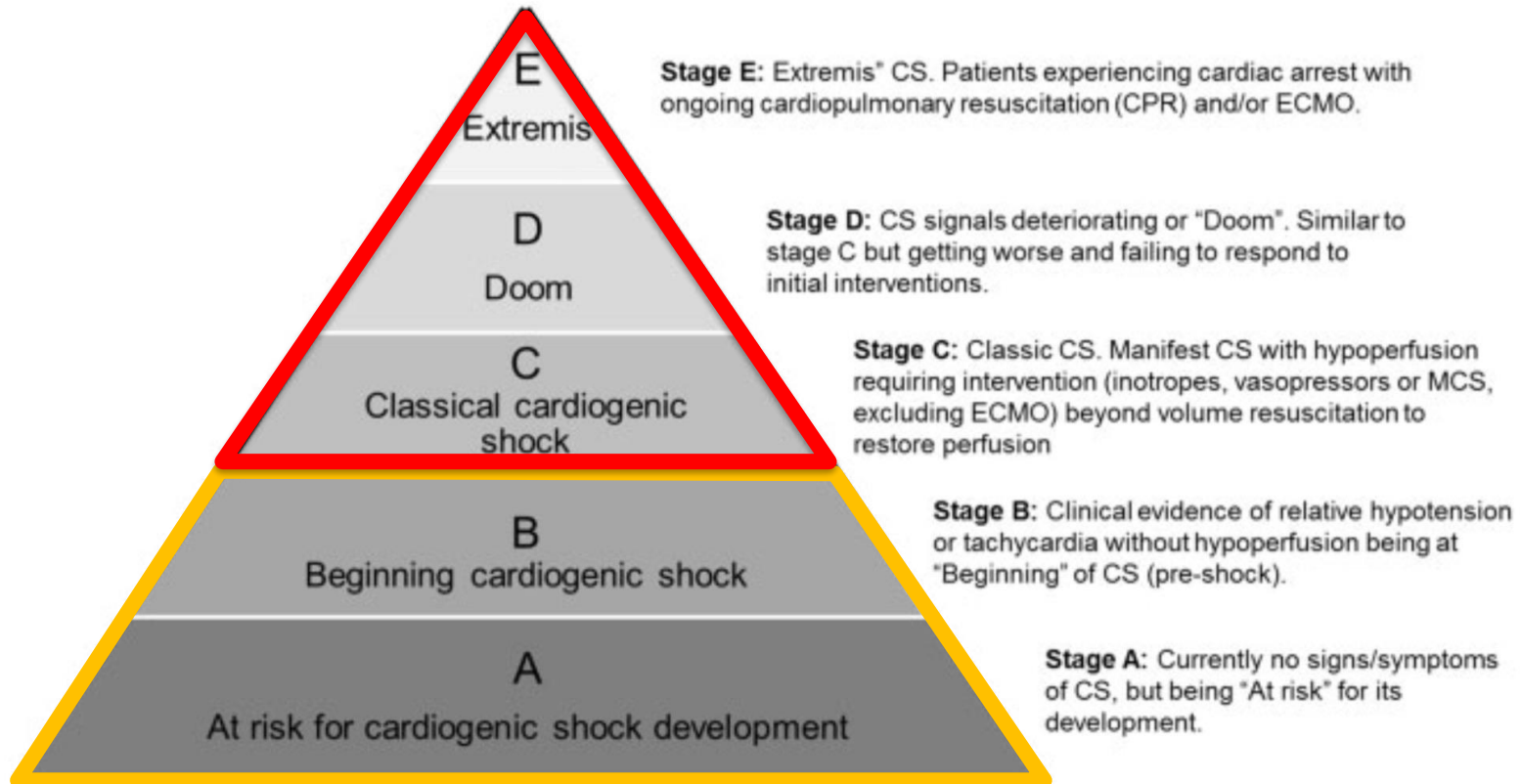
# Pronostic du choc cardiogénique constitué



# Le temps passe plus vite dans le choc cardiogénique !

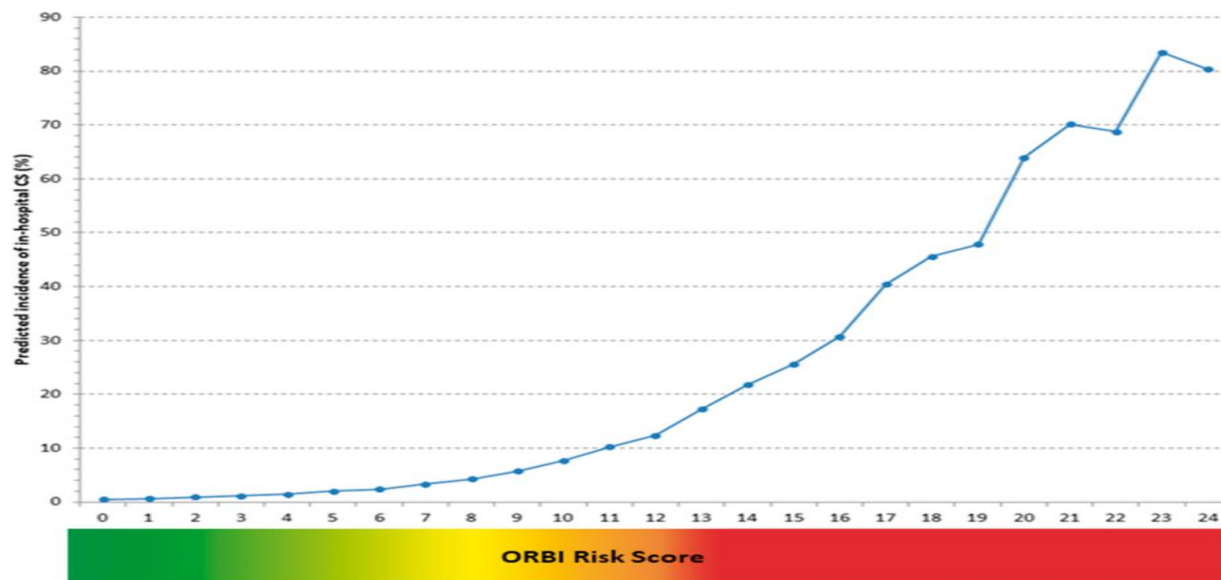


# Choc cardiogénique : Anticiper !



# Penser au choc avant le choc → Facteurs prédictifs

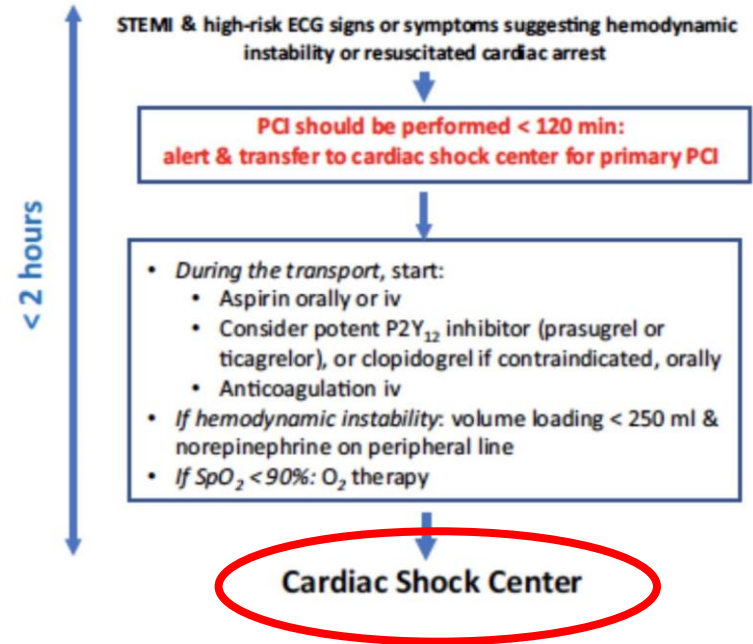
Variable	Points
Age > 70 years old	2
Previous stroke / TIA	2
Presentation as cardiac arrest	3
Anterior myocardial infarction	1
First medical contact-to-pPCI delay > 90 min	2
Killip class II on admission	2
Killip class III on admission	6
Heart rate > 90/min on admission	3
SBP < 125 mmHg and PP < 45 mmHg on admission	4
Glycaemia > 10 mmol/l on admission	3
Culprit lesion of the left main	5
Post-pPCI TIMI flow < 3	5



Risk categories		
Category	Score	Observed incidence of CS
Low	0-7	1.3
Low-to-intermediate	8-10	6.6
Intermediate-to-high	11-12	11.7
High	≥ 13	31.8

# Penser au choc avant le choc → Facteurs prédictifs

- Âge
- **Fréquence cardiaque > 90**
- Facteurs de risque: diabète
- ATCD d'IDM, de PAC
- **Classe killip > I**
- **Localisation IDM antérieur**
- **Nb dérivations ECG ST+**
- Altération FEVG



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Merci de votre attention

