

# **Cuando revascularizar un Síndrome Coronario Crónico**

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## Cuando “hacer algo” en Medicina

**Calidad  
de Vida**

**Cantidad  
de Vida**

**Ahorro  
Económico**

# Cuando “Revascularizar” en Síndromes Coronarios Crónicos

Angina limitante  
Angina “no limitante”  
Angina desapercibida

Muerte/IM  
<5% al año

ICP rutina  
no C-E

Group	Death Rate at		
	5 yrs	10 yrs	14 yrs
1VD & OMT	8%	29%	37%
1VD & PCI	6%	24%	39%
2VD & OMT	11%	23%	47%
2VD & PCI	8%	29%	47%
3VD & OMT	15%	36%	50%
3VD & PCI	16%	35%	53%

*Entonces.....*



*¿Cuándo Revascularizar un  
Síndrome Coronario Crónico?*

*COURAGE Nucl*

*FAME, DEFER,  
FAME-2,  
DEFINE FLAIR*

*MASS-II*

*ISCHEMIA*

*COURAGE*

*BARI-2D*

*STICH*

**Mensaje I. Como norma, hoy en día no deberíamos diagnosticar una enfermedad coronaria sin una confirmación anatómica**

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Optimal Medical Therapy with or without PCI  
for Stable Coronary Disease

**Estudio COURAGE**

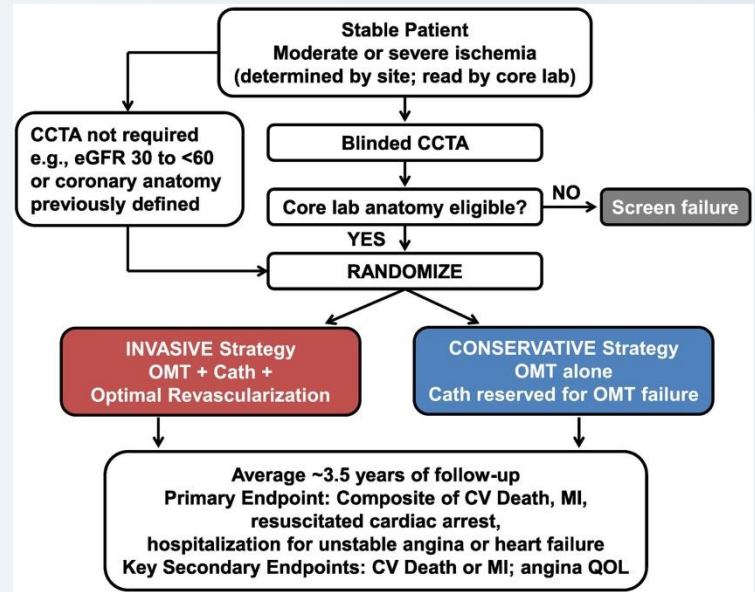
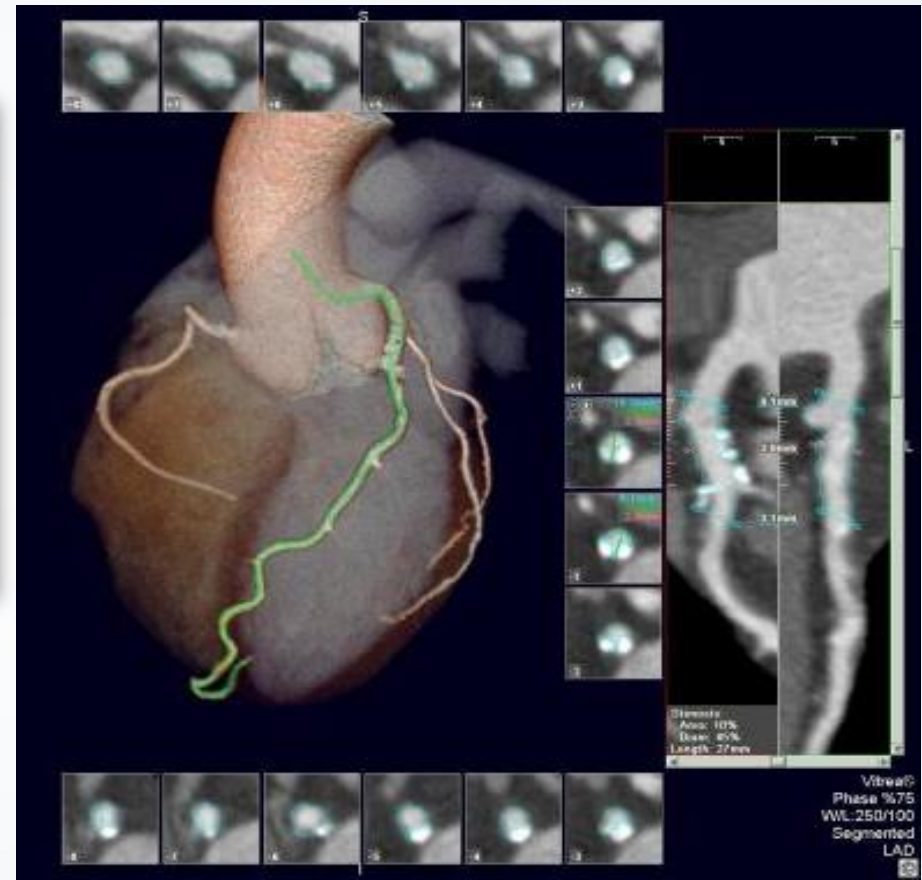
**STUDY POPULATION**

Patients with stable coronary artery disease and those in whom initial Canadian Cardiovascular Society (CCS) class IV angina subsequently stabilized medically were included in the study. Entry criteria included stenosis of at least 70% in at least one proximal epicardial coronary artery and objective evidence of myocardial ischemia (substantial changes in ST-segment depression or T-wave inversion on the resting electrocardiogram or inducible ischemia with either exercise or pharma-

**Table 2. Primary and Secondary End Points after a Median Follow-up of 4.8 Years.<sup>a</sup>**

End Point	All Participants (N=4146)	Standard Care (N=2073)		Hazard Ratio (95% CI) <sup>†</sup>
		Standard Care (N=2073)	Standard Care plus CTA (N=2073)	
Primary end point: death from CHD or non-fatal myocardial infarction <sup>‡</sup>	129 (3.1)	81 (3.9)	48 (2.3)	0.59 (0.41–0.84) <sup>§</sup>
<b>Secondary end points</b>				
Death from CHD, nonfatal myocardial infarction, or nonfatal stroke <sup>‡</sup>	160 (3.9)	97 (4.7)	63 (3.0)	0.65 (0.47–0.89)
Nonfatal myocardial infarction	117 (2.8)	73 (3.5)	44 (2.1)	0.60 (0.41–0.87)
Nonfatal stroke	35 (0.8)	20 (1.0)	15 (0.7)	0.74 (0.56–1.00)
<b>Death</b>				
From CHD <sup>‡</sup>	13 (0.3)	9 (0.4)	4 (0.2)	0.46 (0.14–1.48)
From any cause	86 (2.1)	43 (2.1)	43 (2.1)	1.02 (0.67–1.55)
Cardiovascular	17 (0.4)	12 (0.6)	5 (0.2)	0.43 (0.15–1.22)
Noncardiovascular	69 (1.7)	31 (1.5)	38 (1.8)	1.24 (0.77–2.00)
<b>Procedures</b>				
Invasive coronary angiography	993 (24.0)	502 (24.2)	491 (23.7)	1.00 (0.88–1.13)
Revascularization <sup>¶</sup>	546 (13.2)	267 (12.9)	279 (13.5)	1.07 (0.91–1.27)
Percutaneous coronary intervention	431 (10.4)	212 (10.2)	219 (10.6)	1.06 (0.88–1.28)
Coronary-artery bypass grafting	131 (3.2)	62 (3.0)	69 (3.3)	1.12 (0.80–1.58)

## Estudio SCOT-HEART



## Estudio ISCHEMIA

**Table 2 91 day–3.5 year cumulative risk and hazard ratios with 95% confidence intervals for the composite endpoint**

	No. patients	No. events	Risk <sup>a</sup> % (95% CI)	Hazard ratio (95% CI)	
				Unadjusted	Adjusted <sup>b</sup>
No CAD	9299	140	1.51 (1.28–1.78)	1 (reference)	1 (reference)
Non-obstructive CAD	4894	161	3.29 (2.83–3.83)	2.20 (1.76–2.76)	1.28 (1.01–1.63)
Obstructive CAD	2737	185	6.76 (5.88–7.77)	4.62 (3.71–5.75)	2.25 (1.73–2.92)
One-vessel	1885	92	4.88 (4.00–5.96)	3.30 (2.53–4.29)	1.83 (1.37–2.44)
Two-vessel	612	57	9.32 (7.27–11.91)	6.46 (4.75–8.80)	2.97 (2.09–4.22)
Three-vessel/left main	240	36	15.00 (11.06–20.18)	10.71 (7.43–15.45)	4.41 (2.90–6.69)

Composite endpoint comprising late coronary revascularization

## Registro DANÉS



**Mensaje 2. En pacientes con isquemia leve,  
aceptada por médico y el mismo,  
la revascularización de rutina no es la panacea**

# The NEW ENGLAND JOURNAL of MEDICINE

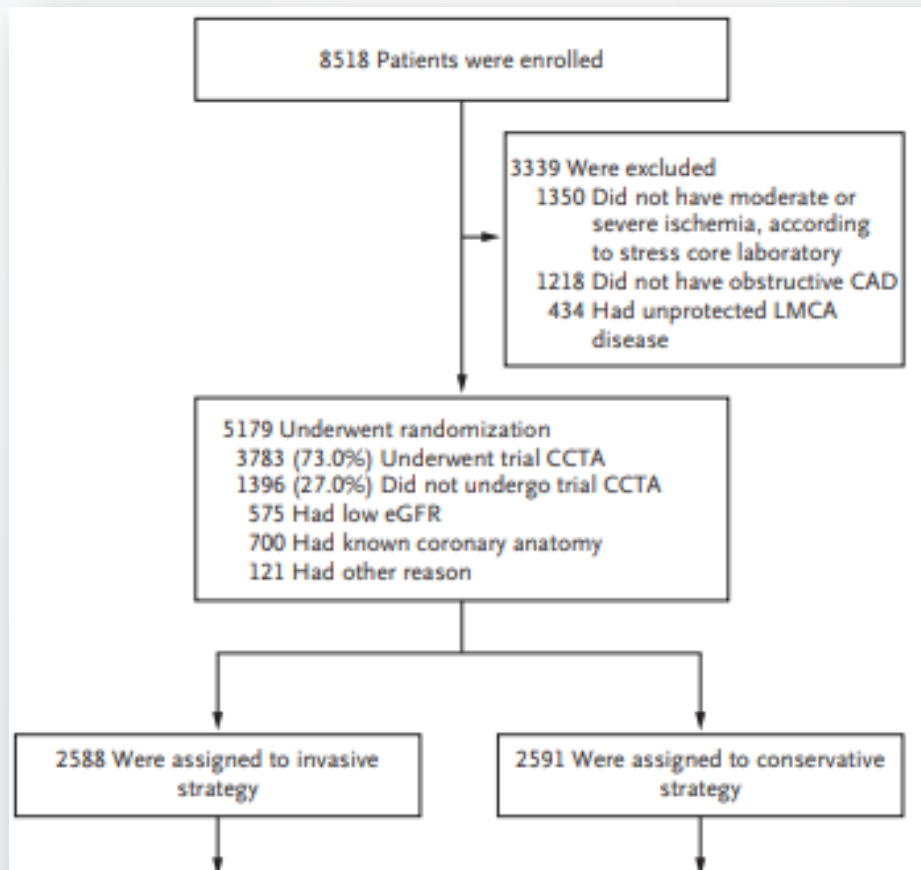
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## Initial Invasive or Conservative Strategy for Stable Coronary Disease

# Estudio ISCHEMIA

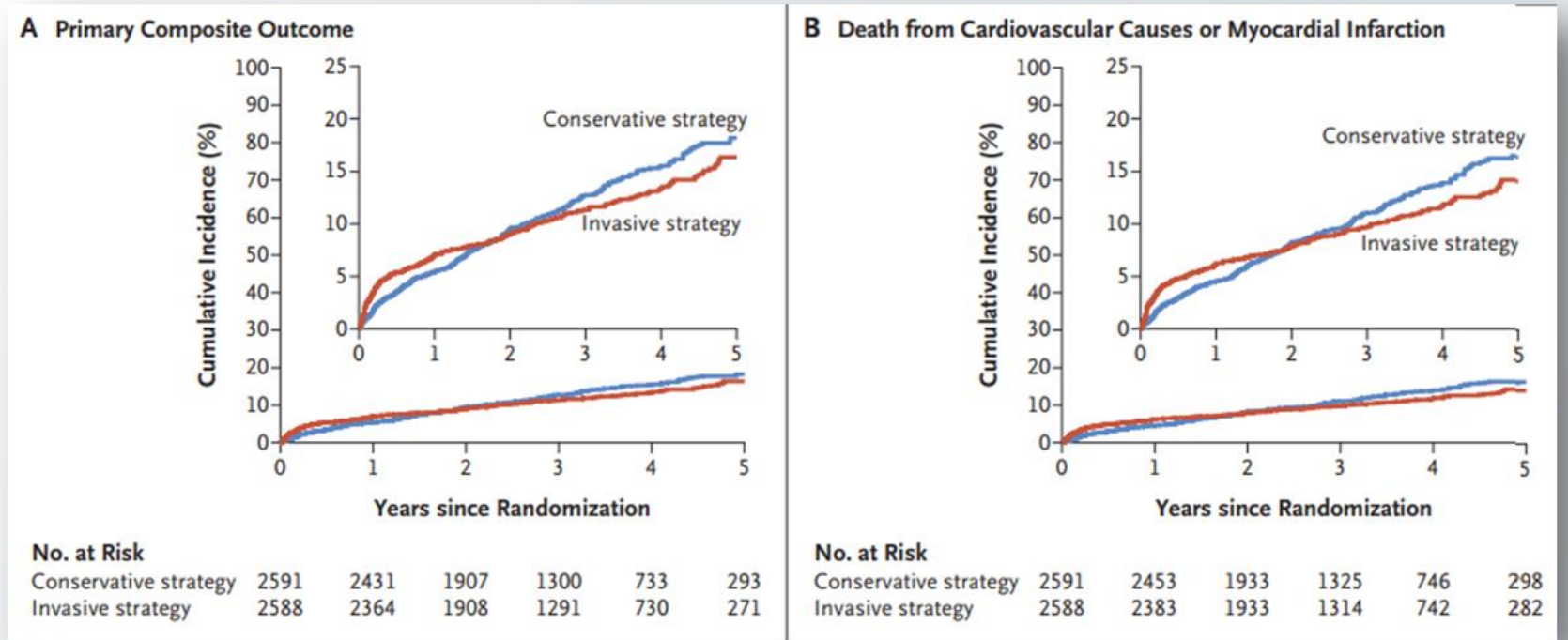


# Estudio ISCHEMIA

**Proyectados** 8000 pacientes con isquemia moderada a severa

**Reclutados** 5000 pacientes, con isquemia de moderada a ligera

10 años y 100 M\$ después.....



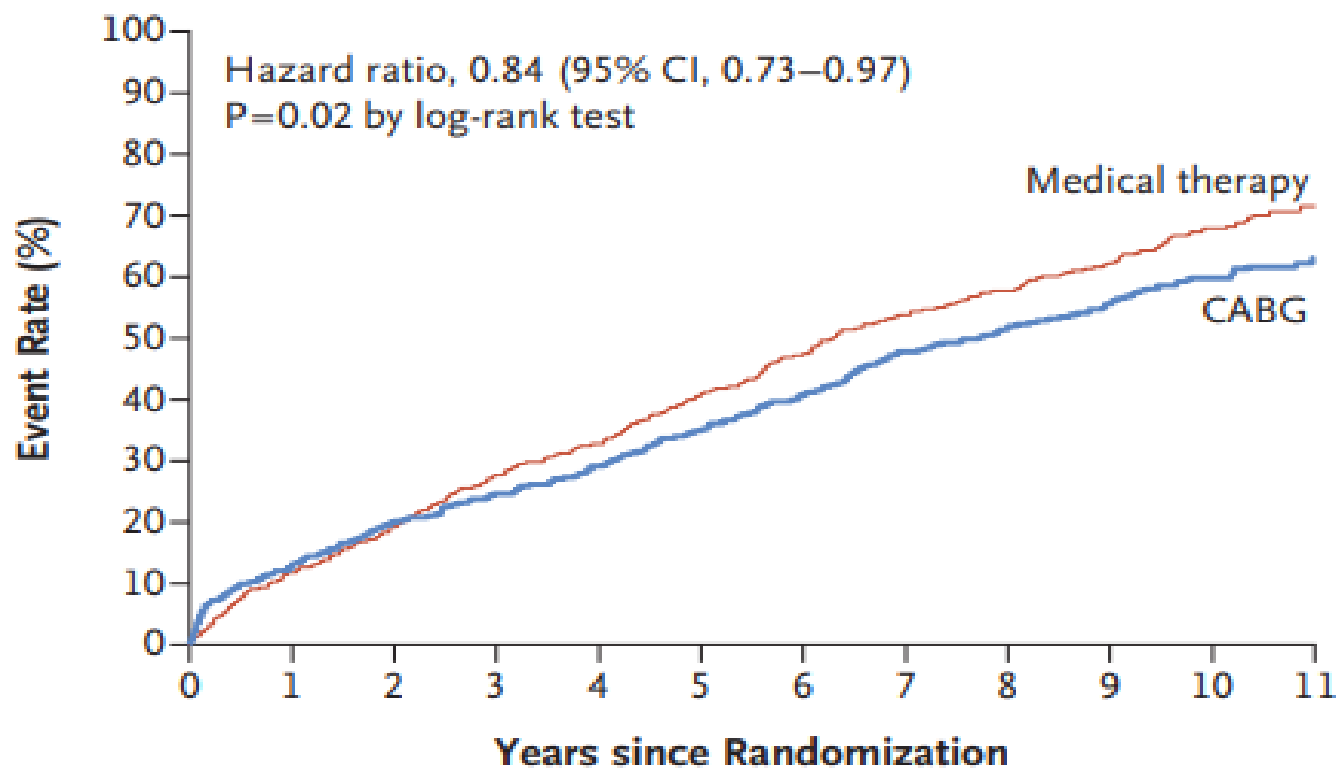
# **Mensaje 3. Como norma, revascularice a los pacientes con disfunción ventricular**

**\*el estudio de viabilidad  
puede confundir más  
que ayudar**

Coronary-Artery Bypass Surgery in Patients with Ischemic  
Cardiomyopathy

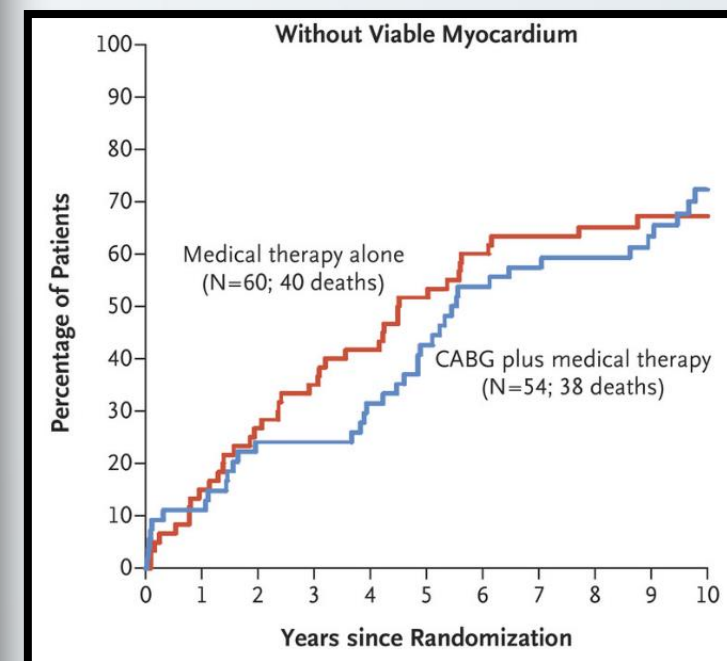
# Estudio STICH

## A Death from Any Cause (Primary Outcome)

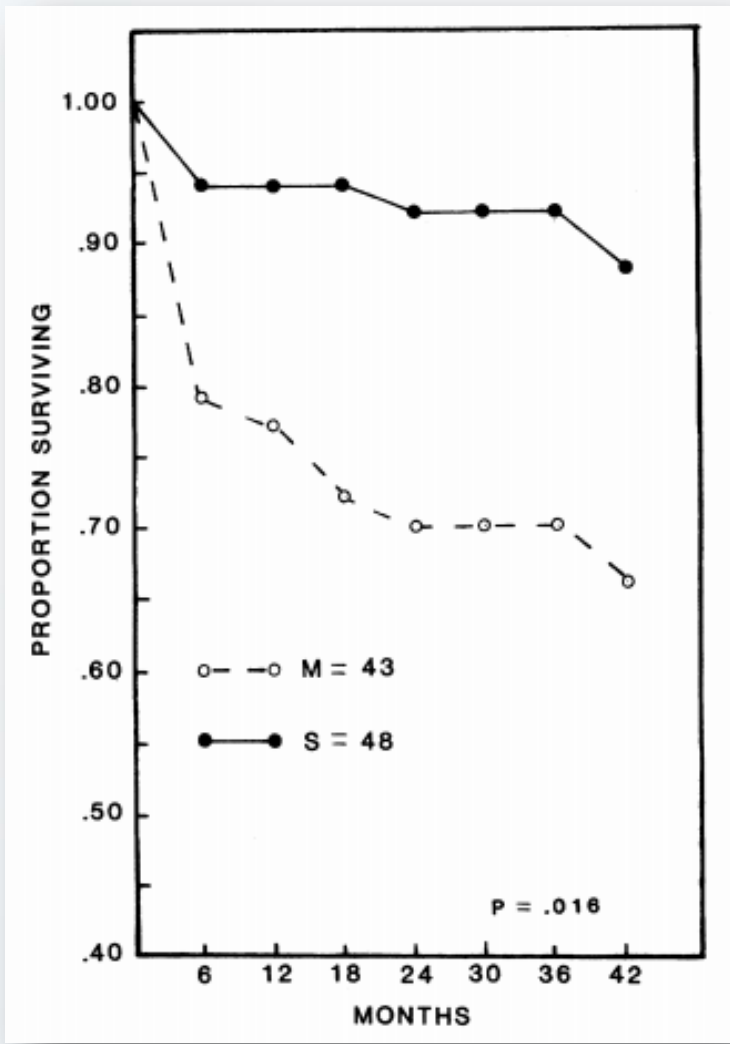


**No. at Risk**

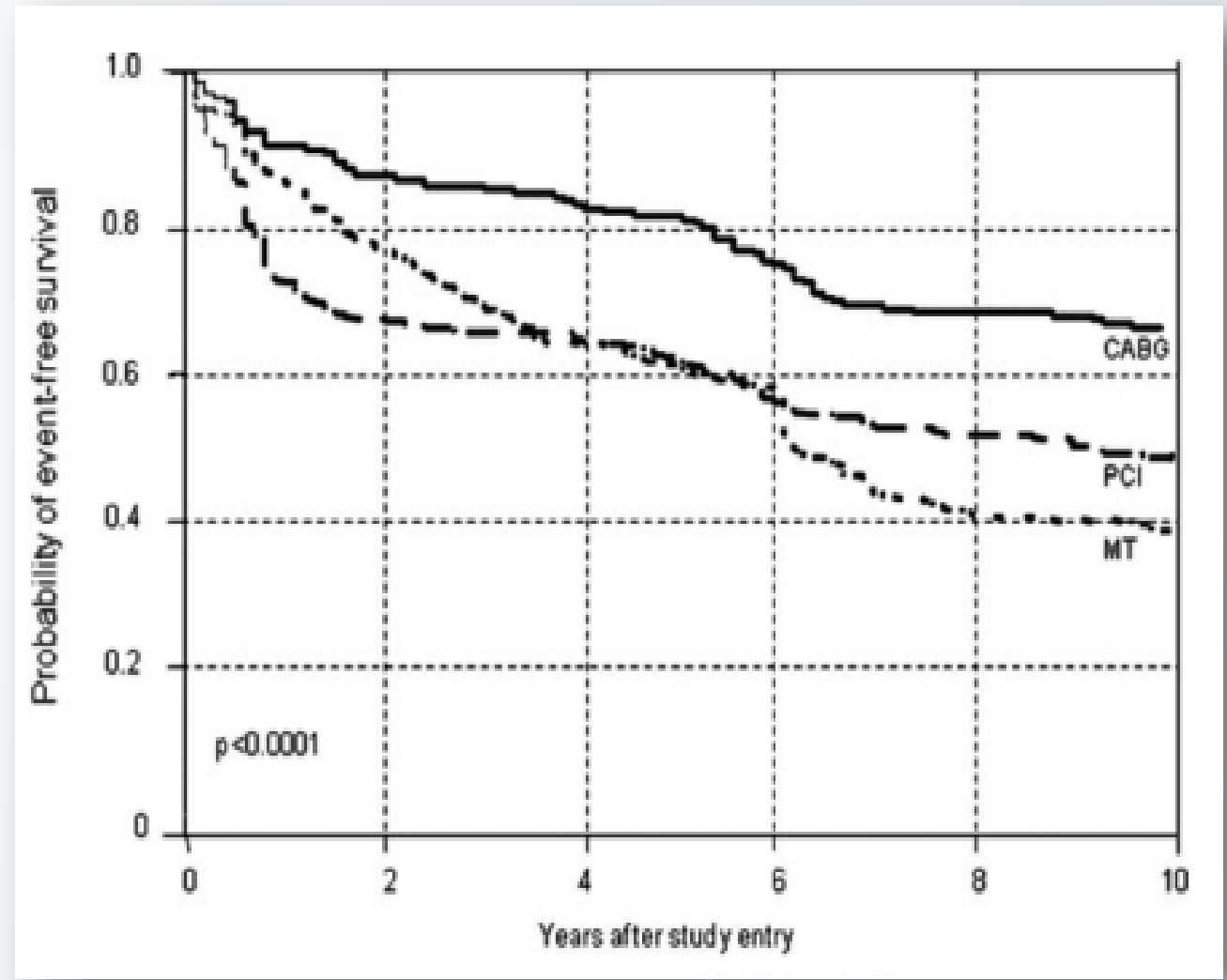
Medical therapy	602	532	487	435	404	357	315	274	248	164	82	37
CABG	610	532	487	460	432	392	356	312	286	205	103	42



**Mensaje 4. Revascularice a los pacientes con  
anatomías de riesgo**  
*(esto es, enfermedad de tronco o multivaso)*



VACS. Circulation. 1982.  
Enfermedad de TCI



MASS-II. Circulation. 2010.  
Enfermedad de 2 ó 3 vasos

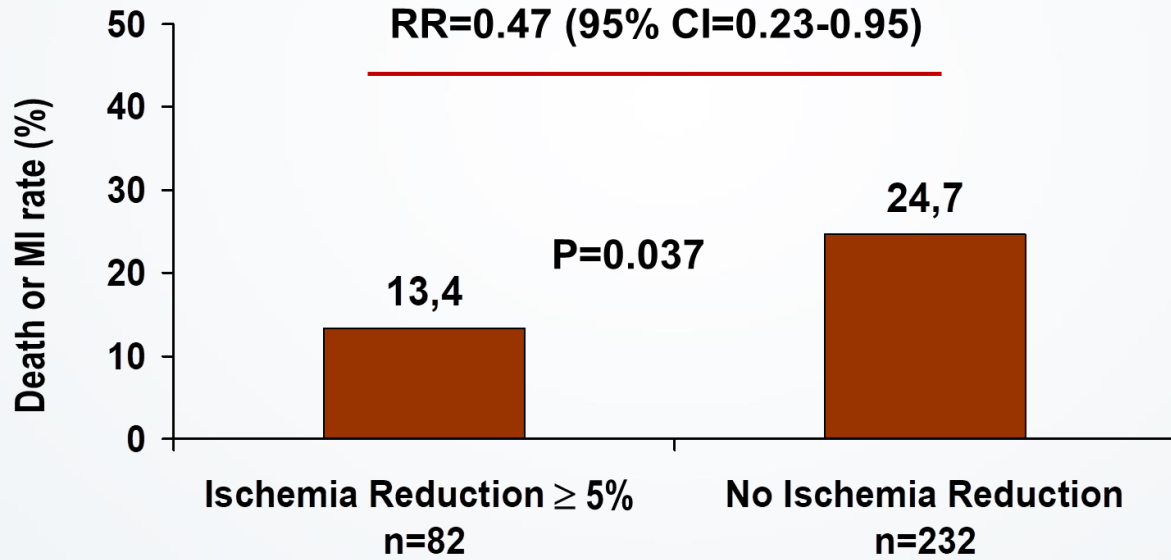
**Mensaje 5. Revascularice a pacientes con un grado extenso de isquemia**



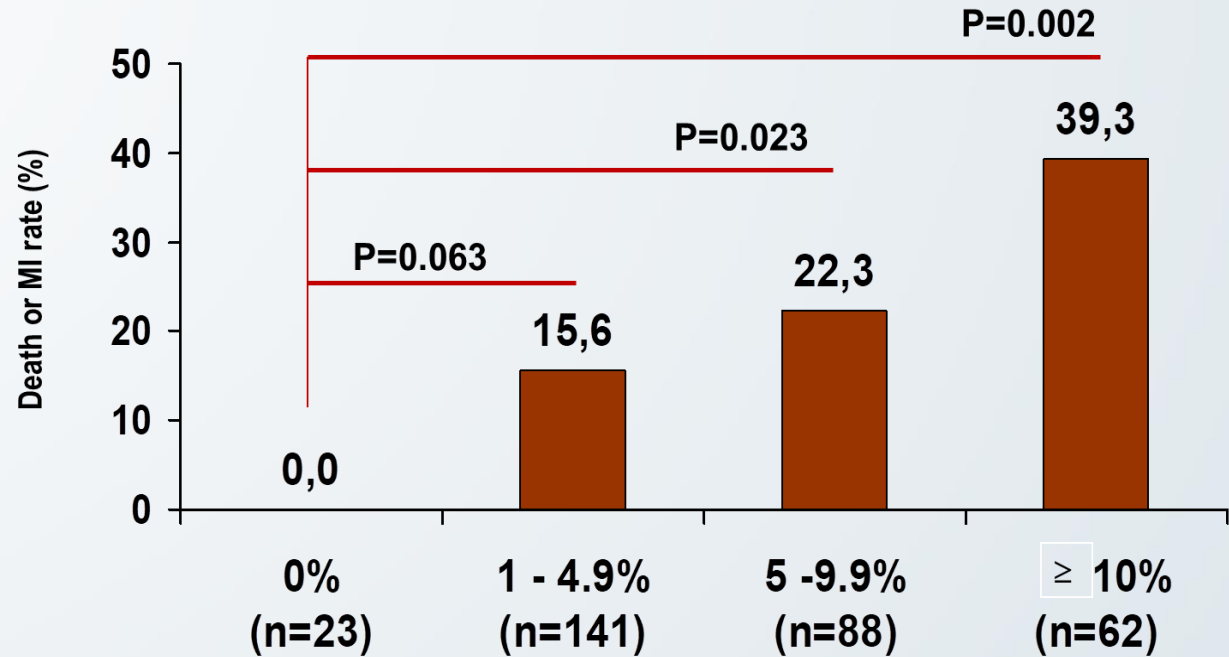
## Imaging

### Optimal Medical Therapy With or Without Percutaneous Coronary Intervention to Reduce Ischemic Burden

Results From the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) Trial Nuclear Substudy



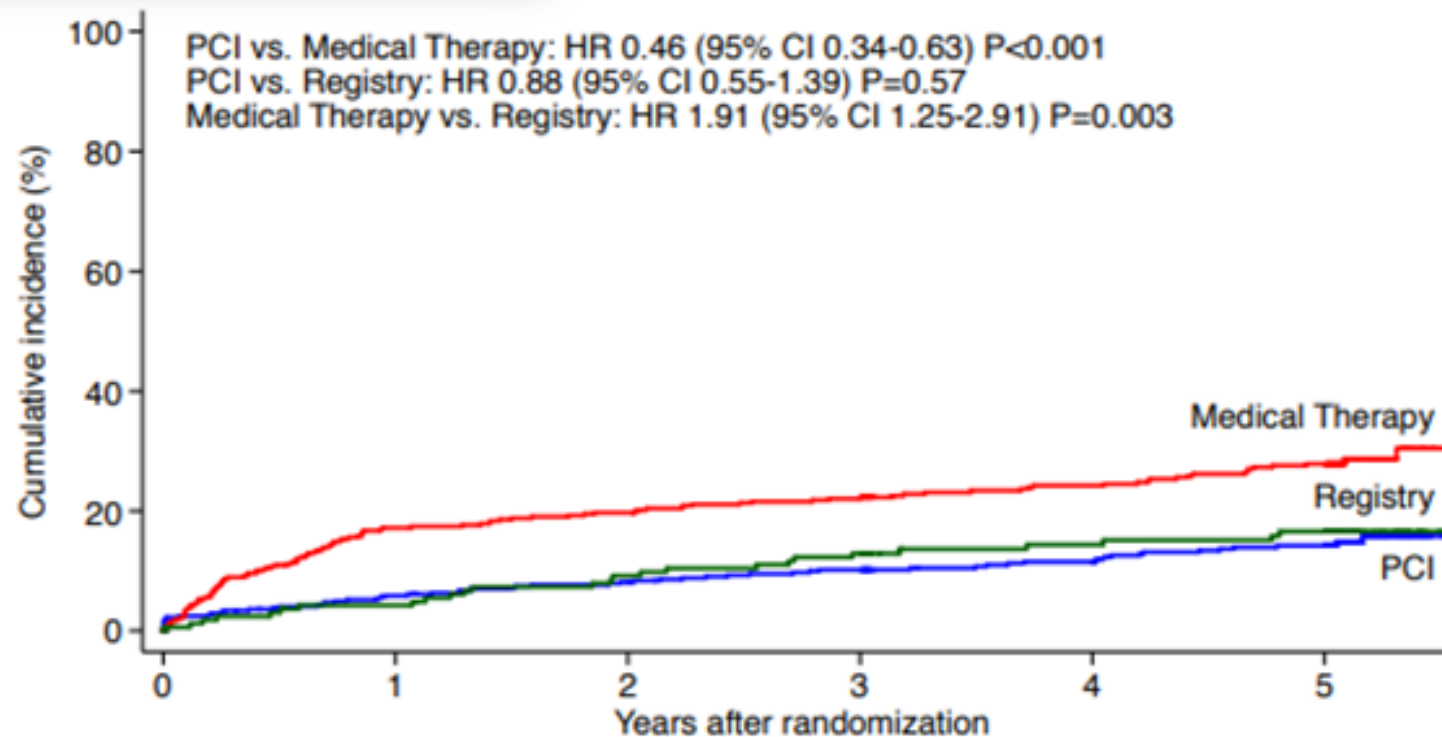
## COURAGE Nuclear



**Mensaje 6. Como le seguirán enviando pacientes a cateterismo, tenga en consideración las virtudes de los estudios de fisiología**

Fractional Flow Reserve–Guided PCI versus Medical Therapy  
in Stable Coronary Disease

# Estudio FAME-2



FFR≤0.80 + médico

FFR>0.80 + médico

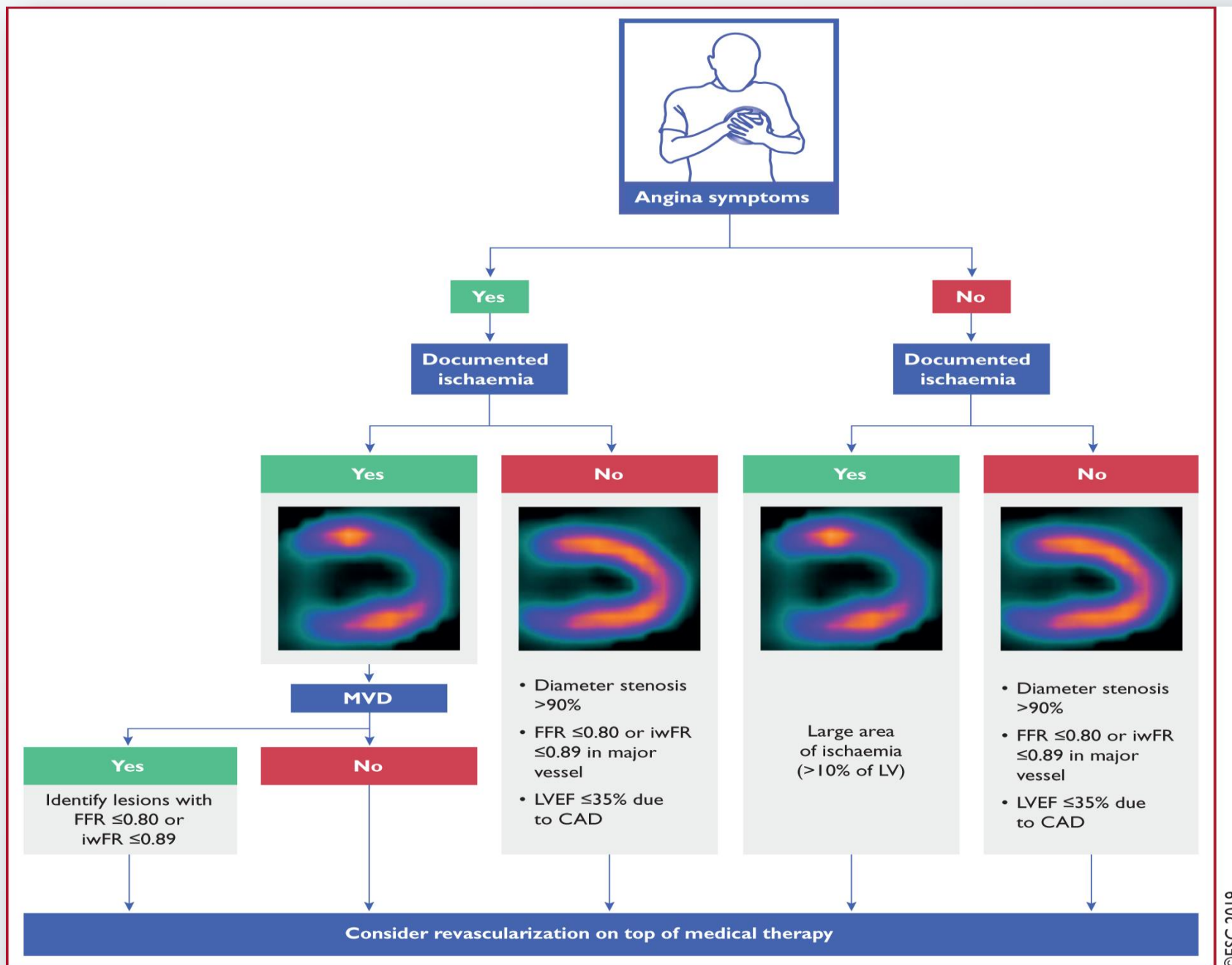
FFR≤0.80 + ICP

No. at risk

Medical Therapy	441	360	349	337	271	258
PCI	447	416	403	391	334	321
Registry	166	156	147	141	116	113

# Recomendaciones de las Guías de Práctica Clínica



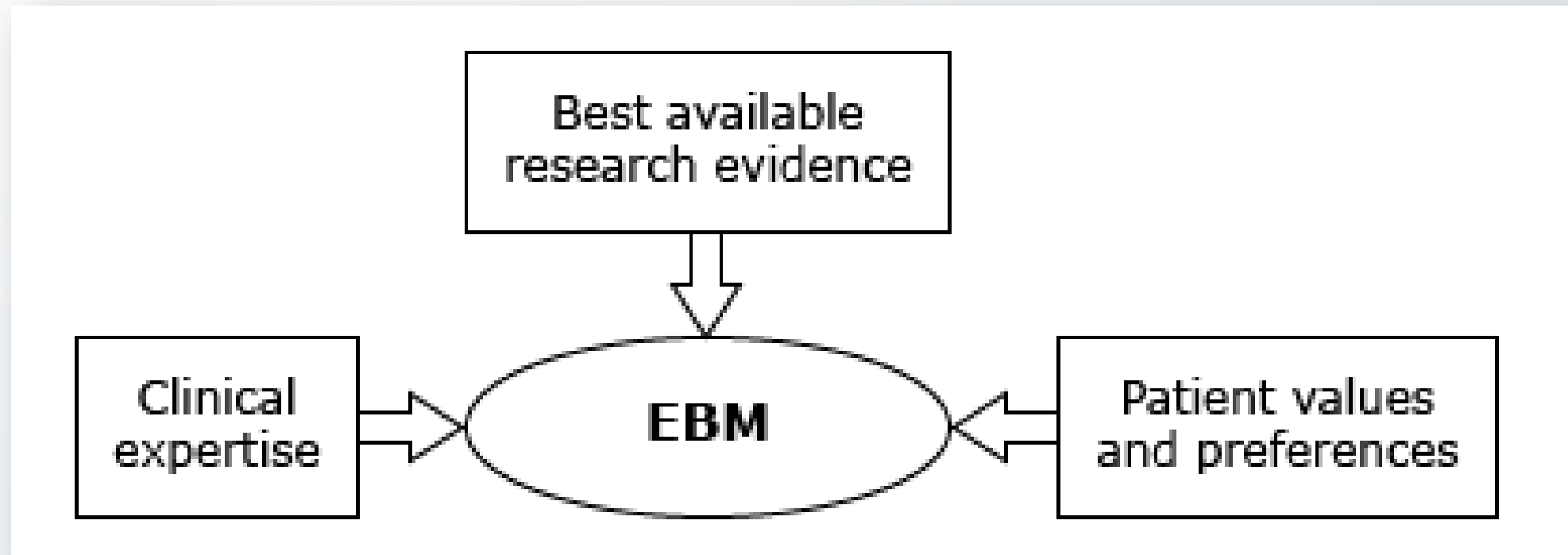


# Indicaciones de revascularización en los Síndromes Coronarios Crónicos

<b>Síntomas</b>	<b>Pronóstico</b>	
<i>Estenosis &gt;90%</i> ó <i>Isquemia documentada</i> ó <i>FFR/iFR patológico</i>	<b><i>Anatomía</i></b>	<b><i>Función</i></b>
	<i>Tronco común</i> <i>DA proximal</i> <i>Arteria única</i>	<i>MTV c/ FEVI ≤35%</i> <i>Isquemia &gt;10%</i> <i>FFR/iFR patológico</i>

## Conclusiones

Revascularización en el SCC... el escenario que define el arte de aplicar la Medicina Basada en la Evidencia



# GRACIAS

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