DAP prolongada tras ICP en el DIABÉTICO

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Presentación Caso

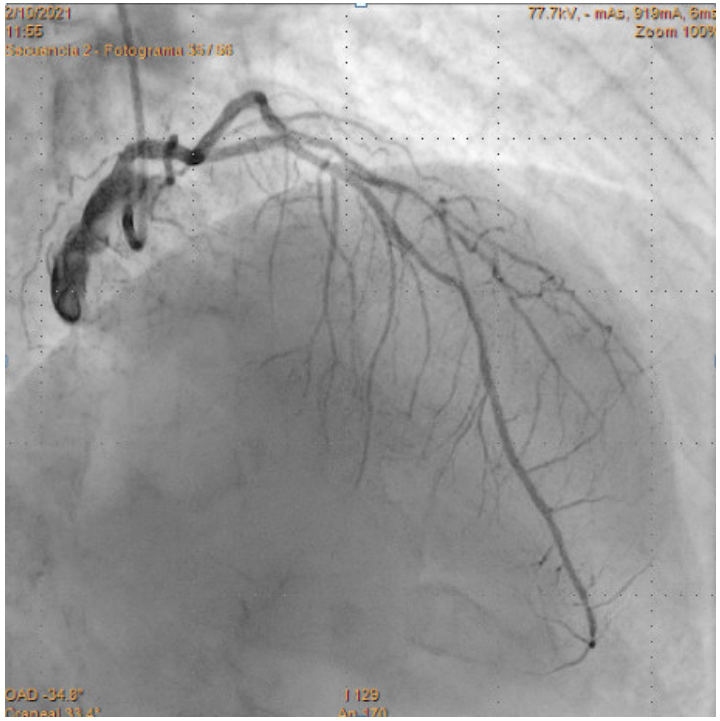
- Varón, 69a
- **Hª previa**
  - DL, DM2, exfumador
  - Hepatitis autoinmune
  - COVID19 (Mar/20)
  - CPI tardía familiar

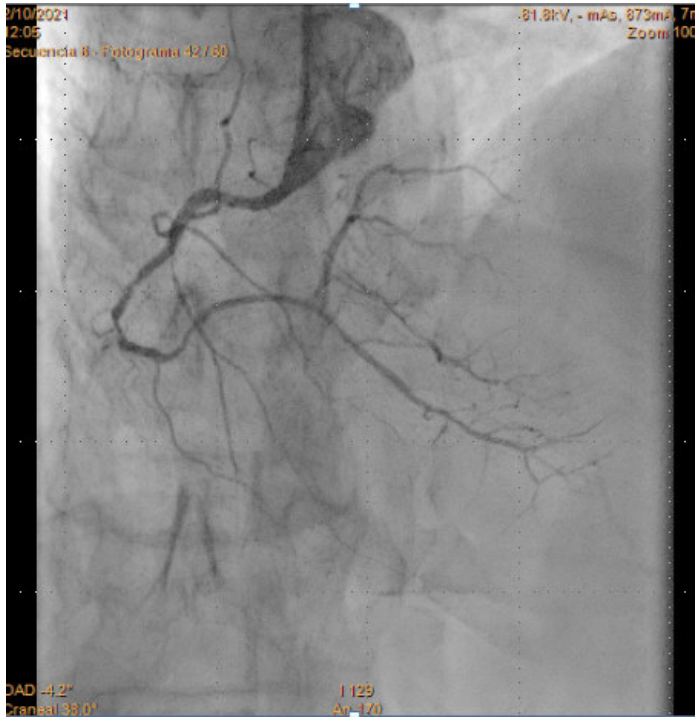
- **CEX Cardiología**
  - AE típica
  - Persistencia BB/LAN
  - PE (+) 4.8 METS
  - HB 13.4, creat 1.14
  - VI normal

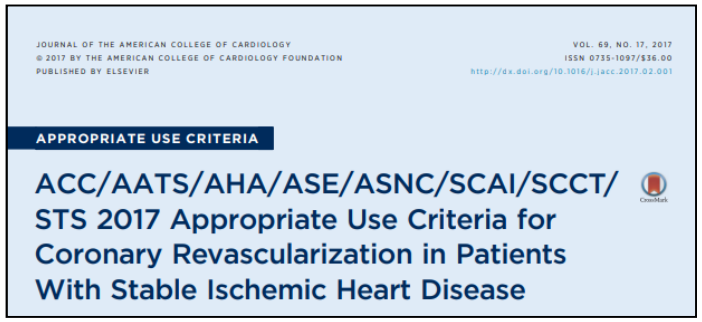
Janumet, Lantus, Imurel, pravastatina, omeprazol, Lorazepam, adiro 100

Coronariografía

(09/02/2021)







Opciones de Revascularización

TABLE 1.2 Two-Vessel Disease

Appropriate Use Score (1-9)

Two-Vessel Disease

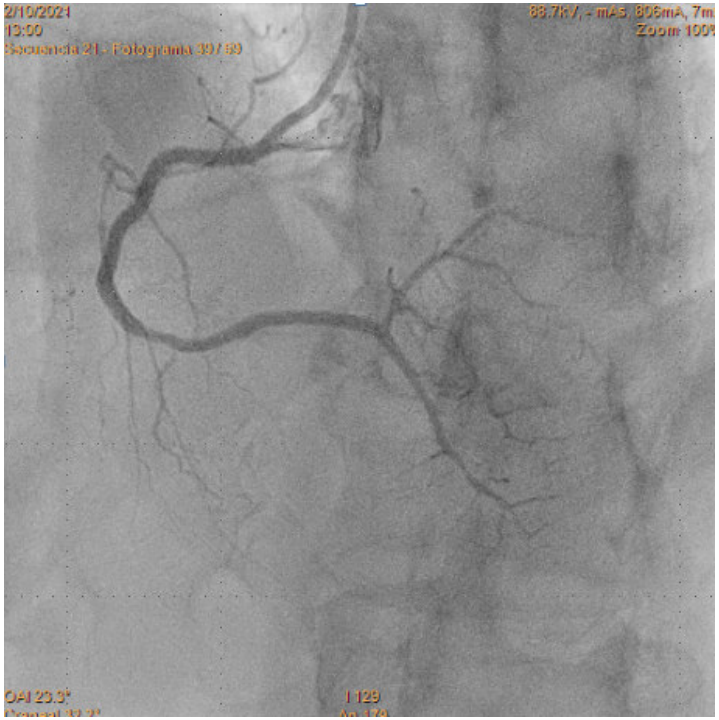
Indication	Asymptomatic				Ischemic Symptoms			
	Not on AA Therapy or With AA Therapy		Not on AA Therapy		On 1 AA Drug (BB Preferred)		On ≥2 AA Drugs	
	PCI	CABG	PCI	CABG	PCI	CABG	PCI	CABG
No Proximal LAD Involvement								
7. ■ Low-risk findings on noninvasive testing	R (3)	R (2)	M (4)	R (3)	M (5)	M (4)	A (7)	M (6)
8. ■ Intermediate- or high-risk findings on noninvasive testing	M (5)	M (4)	M (6)	M (5)	A (7)	M (6)	A (8)	A (7)
9. ■ No stress test performed or, if performed, results are indeterminate ■ FFR ≤0.80* in both vessels	M (5)	M (4)	M (6)	M (4)	A (7)	M (5)	A (8)	A (7)

Patel MR, et al. J Am Coll Cardiol. 2017:2212

Intervencionismo a CD

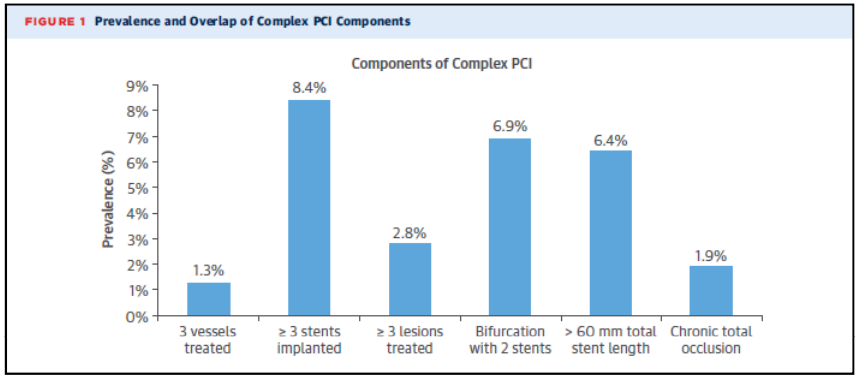
(Ad Hoc)

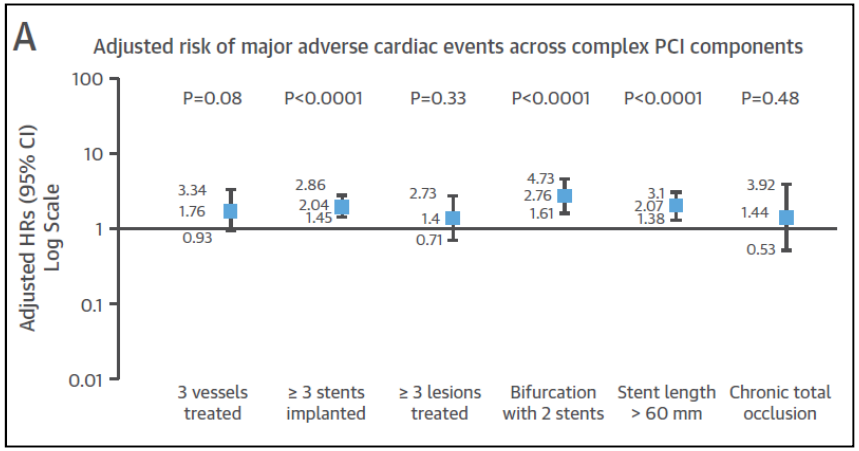
- CG AL1
- Guías a PL e IVP
- Predilatación NC
- ✓ CDd-IVP: SFA 2.25/30, SFA 2.25/15 solapados
- CDp-m SFA 2.5/33, SFA 2.75/33 solapados
- Postdilatación NC



Longitud total: 111 mm

Riesgo de Trombosis tras ICP Complejo





Giustino G, et al. J Am Coll Cardiol. 2016:1851

Variables adicionales de riesgo

Table 2. Myocardial Infarction or Stent Thrombosis Prediction Model and Moderate or Severe Bleeding Prediction Model

	Predictors of Myocardial Infarction or Stent Thrombosis[b]		Predictors of Moderate or Severe Bleeding[c]	
Predictors of Events[a]	HR (95% CI)	*P* Value	HR (95% CI)	*P* Value
Continued thienopyridine vs placebo	0.52 (0.42-0.65)	<.001	1.66 (1.26-2.19)	<.001
Myocardial infarction at presentation	1.65 (1.31-2.07)	<.001		
Prior PCI or prior myocardial infarction	1.79 (1.43-2.23)	<.001		
History of CHF or LVEF <30%	1.88 (1.35-2.62)	<.001		
Vein graft stent	1.75 (1.13-2.73)	.01		
Stent diameter <3 mm	1.61 (1.30-1.99)	<.001		
Paclitaxel-eluting stent	1.57 (1.26-1.97)	<.001		
Cigarette smoking	1.40 (1.11-1.76)	.01		
Diabetes mellitus	1.38 (1.10-1.72)	.01		
Age, per 10 y			1.54 (1.34-1.78)	<.001
Peripheral arterial disease	1.49 (1.05-2.13)	.03	2.16 (1.46-3.20)	<.001
Hypertension	1.37 (1.03-1.82)	.03	1.45 (1.00-2.11)	.05
Renal insufficiency/failure	1.55 (1.03-2.32)	.04	1.66 (1.04-2.66)	.03

Yeh RW, et al. JAMA. 2016:1735.

ESC European Society of Cardiology
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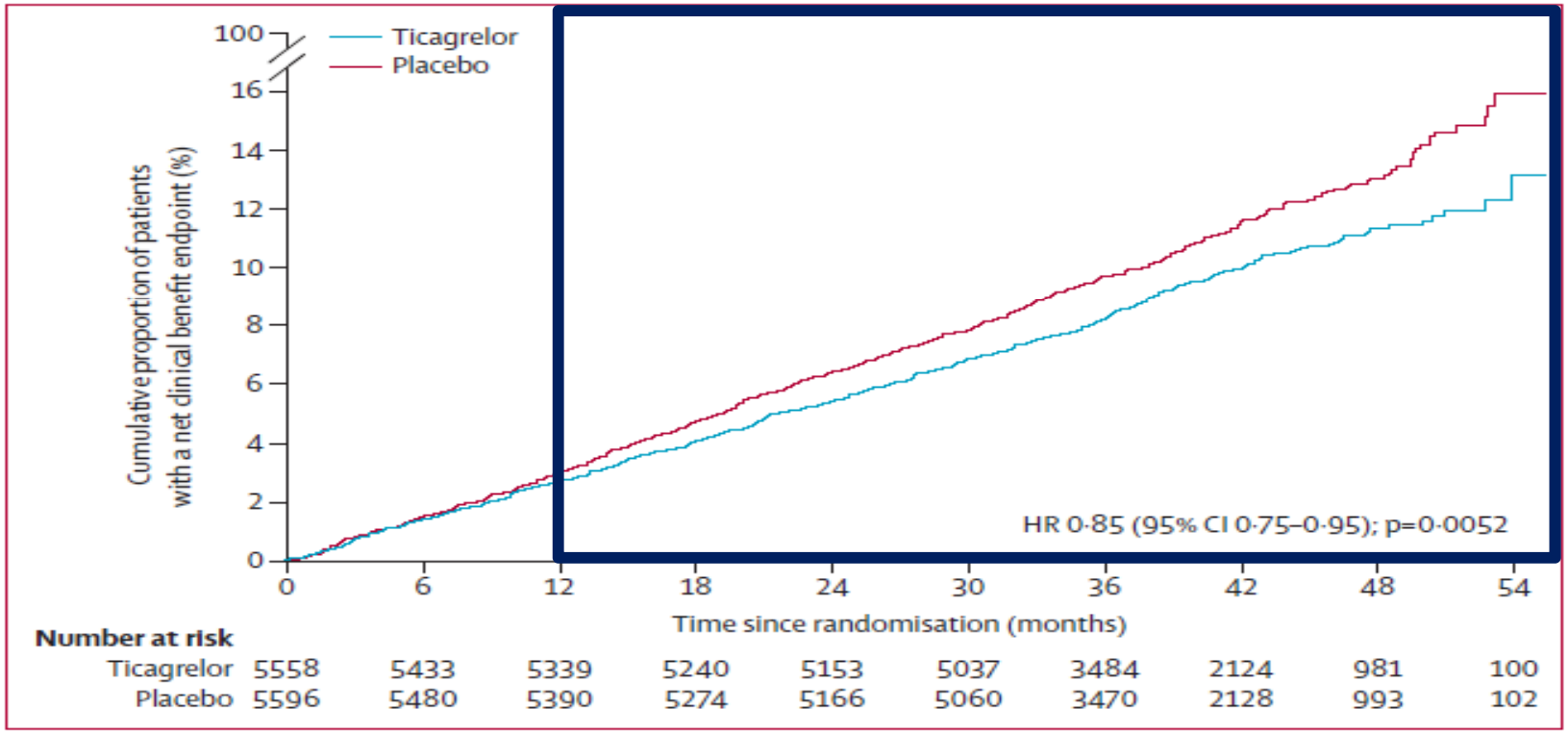
ESC GUIDELINES

2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

The Task Force for the diagnosis and management of chronic coronary syndromes of the European Society of Cardiology (ESC)

Recommendations	Class[a]	Level[b]
Antithrombotic therapy in patients with CCS and in sinus rhythm		
Aspirin 75–100 mg daily is recommended in patients with a previous MI or revascularization.[270]	I	A
Clopidogrel 75 mg daily is recommended as an alternative to aspirin in patients with aspirin intolerance.[273]	I	B
Clopidogrel 75 mg daily may be considered in preference to aspirin in symptomatic or asymptomatic patients, with either PAD or a history of ischaemic stroke or transient ischaemic attack.[273]	IIb	B
Aspirin 75–100 mg daily may be considered in patients without a history of MI or revascularization, but with definitive evidence of CAD on imaging.	IIb	C
Adding a second antithrombotic drug to aspirin for long-term secondary prevention should be considered in patients with a **high risk** of ischaemic events[c] and without high bleeding risk[d] (see *Table 9* for options).[289,296,297,307]	IIa	A
Adding a second antithrombotic drug to aspirin for long-term secondary prevention may be considered in patients with at least a **moderately increased risk** of ischaemic events[e] and without high bleeding risk[d] (see *Table 9* for options).[289,296,297,307]	IIb	A
Prasugrel or ticagrelor may be considered, at least as initial therapy, in specific high-risk situations of elective stenting (e.g. suboptimal stent deployment or other procedural characteristics associated with high risk of stent thrombosis, complex left main stem, or multivessel stenting) or if DAPT cannot be used because of aspirin intolerance.	IIb	C

Tiempo



Bhatt DL, et al. Lancet. 2019

Gracias!!!