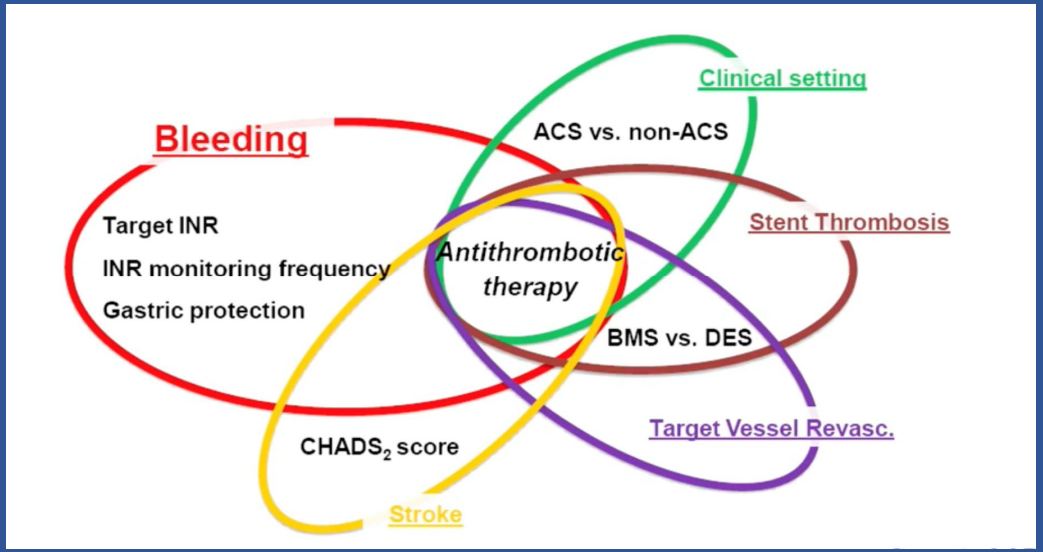
ICP COMPLEJA EN PACIENTE CON SCA Y FIBRILACION AURICULAR TRATADO CON ANTICOAGULACION ORAL

CASO CLINICO

- 71 AÑOS, Várón HTA, DM tipo 2, ex-fumador, IRC (ClCr 30 ml/min), IAM previo
- FA paroxistica en tto con apixaban
- Ingresa por SCASEST
- Cateterismo: ENF severa 3 vasos
- **CHADS2VA2SC=4. HASBLED=4 (alto riego isquemico y de complicaciones hemorragicas al seguimiento)**

Factores a tener en cuenta

- **RIESGO ISQUEMICO** : CHA2DS2-VASC, (Anticoagulación en FA) GRACE, SCORE DAPT (para SCA, duración doble antiagregación (TROMBOSIS STENT…)
- **RIESGO HEMORRAGICO**: HASBLED, DURACIÓN DE DOBLE ANTIAGREGACIÓN , TIPO DE ANTIAGREGANTES Y ANTICOAGULANTE….



SCORE CHA2DS2-VASC: PREDICE RIESO DE SUFRIR UN ICTUS

CHA_2DS_2-VASc	Score
Congestive heart failure	1
Hypertension	1
Age ≥ 75 years	2
Diabetes	1
Stroke/TIA/thromboembolism	2
Vascular disease	1
Age 65-74	1
Female Sex	1

(c) Adjusted stroke rate according to CHA_2DS_2-VASc score

CHA_2DS_2-VASc score	Patients (n=7329)	Adjusted stroke rate (%/year)[b]
0	1	0%
1	422	1.3%
2	1230	2.2%
3	1730	3.2%
4	1718	4.0%
5	1159	6.7%
6	679	9.8%
7	294	9.6%
8	82	6.7%
9	14	15.2%

Lip G, et al. Chest 2010

RIESGO TROMBÓTICO Y ENFERMEDAD CORONARIA

Tabla 2
Factores que influyen en el riesgo isquémico

• Síndrome coronario agudo como evento clínico
• Trombosis del *stent*
• Elevada puntuación GRACE
• Elevada puntuación SYNTAX
• Intervención sobre tronco de la coronaria izquierda o la descendente anterior
• Infarto de miocardio recurrente
• Intervención sobre bifurcación

Lip G, et al. Europace 2019

¿Qué DICEN LAS GUIAS DEL MANEJO TERAPEUTICO?

2018 ESC/EACTS Guidelines on myocardial revascularization

Eur Heart J. 2019 Jan 7;40(2):87-165.

Table 8 Strategies to avoid bleeding complications in oral anticoagulation patients

Assess ischaemic and bleeding risks using validated risk predictors (e.g. CHA_2DS_2-VASc, ABC, and HAS-BLED) with a focus on modifiable risk factors.
Keep triple therapy duration as short as possible; dual therapy after PCI (OAC and clopidogrel) to be considered instead of triple therapy.
One should consider the use of a NOAC instead of a VKA when NOACs are not contraindicated.
Consider a target INR in the lower part of the recommended target range and maximize time in the therapeutic range (i.e. >65%) when a VKA is used.
Clopidogrel is the $P2Y_{12}$ inhibitor of choice.
Use low-dose (≤100 mg daily) aspirin.
Routine use of PPIs.

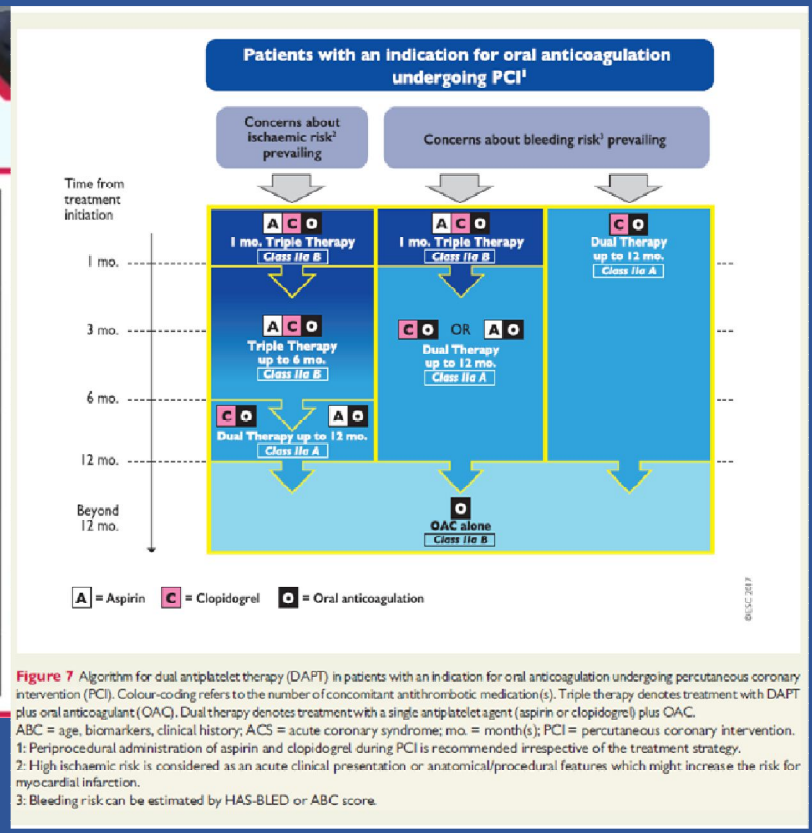


Figure 7 Algorithm for dual antiplatelet therapy (DAPT) in patients with an indication for oral anticoagulation undergoing percutaneous coronary intervention (PCI). Colour-coding refers to the number of concomitant antithrombotic medication(s). Triple therapy denotes treatment with DAPT plus oral anticoagulant (OAC). Dual therapy denotes treatment with a single antiplatelet agent (aspirin or clopidogrel) plus OAC.
ABC = age, biomarkers, clinical history; ACS = acute coronary syndrome; mo. = month(s); PCI = percutaneous coronary intervention.
1: Periprocedural administration of aspirin and clopidogrel during PCI is recommended irrespective of the treatment strategy.
2: High ischaemic risk is considered as an acute clinical presentation or anatomical/procedural features which might increase the risk for myocardial infarction.
3: Bleeding risk can be estimated by HAS-BLED or ABC score.

Recommendations for AF Complicating ACS

Referenced studies that support new or modified recommendations are summarized in Online Data Supplement 8.

COR	LOE	Recommendations
I	B-R	1. For patients with ACS and AF at increased risk of systemic thromboembolism (based on CHA_2DS_2-VASc risk score of 2 or greater), anticoagulation is recommended unless the bleeding risk exceeds the expected benefit (S7.4-1–S7.4-3). **MODIFIED**: New published data are available. LOE was updated from C in the 2014 AF Guideline to B-R. Anticoagulation options are described in supportive text.
I	C	2. Urgent direct-current cardioversion of new-onset AF in the setting of ACS is recommended for patients with hemodynamic compromise, ongoing ischemia, or inadequate rate control.
I	C	3. Intravenous beta blockers are recommended to slow a rapid ventricular response to AF in patients with ACS who do not display HF, hemodynamic instability, or bronchospasm.
IIa	B-NR	4. If triple therapy (oral anticoagulant, aspirin, and $P2Y_{12}$ inhibitor) is prescribed for patients with AF at increased risk of stroke (based on CHA_2DS_2-VASc risk score of 2 or greater) who have undergone percutaneous coronary intervention (PCI) with stenting for ACS, it is reasonable to choose clopidogrel in preference to prasugrel (S7.4-4, S7.4-5). **NEW**: New published data are available.
IIa	B-R	5. In patients with AF at increased risk of stroke (based on CHA_2DS_2-VASc risk score of 2 or greater) who have undergone PCI with stenting for ACS, double therapy with a $P2Y_{12}$ inhibitor (clopidogrel or ticagrelor) and dose-adjusted vitamin K antagonist is reasonable to reduce the risk of bleeding as compared with triple therapy (S7.4-3, S7.4-6–S7.4-8). **NEW**: New RCT data and data from 2 registries and a retrospective cohort study are available.
IIa	B-R	6. In patients with AF at increased risk of stroke (based on CHA_2DS_2-VASc risk score of 2 or greater) who have undergone PCI with stenting for ACS, double therapy with $P2Y_{12}$ inhibitors (clopidogrel) and low-dose rivaroxaban 15 mg daily is reasonable to reduce the risk of bleeding as compared with triple therapy (S7.4-2). **NEW**: New published data are available.
IIa	B-R	7. In patients with AF at increased risk of stroke (based on CHA_2DS_2-VASc risk score of 2 or greater) who have undergone PCI with stenting for ACS, double therapy with a $P2Y_{12}$ inhibitor (clopidogrel) and dabigatran 150 mg twice daily is reasonable to reduce the risk of bleeding as compared with triple therapy (S7.4-1). **NEW**: New published data are available.

2019 AHA/ACC/HRS Focused Update of the 2014 AHA/ACC/HRS Guideline for the Management of Patients With Atrial Fibrillation

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society

Developed in Collaboration With the Society of Thoracic Surgeons

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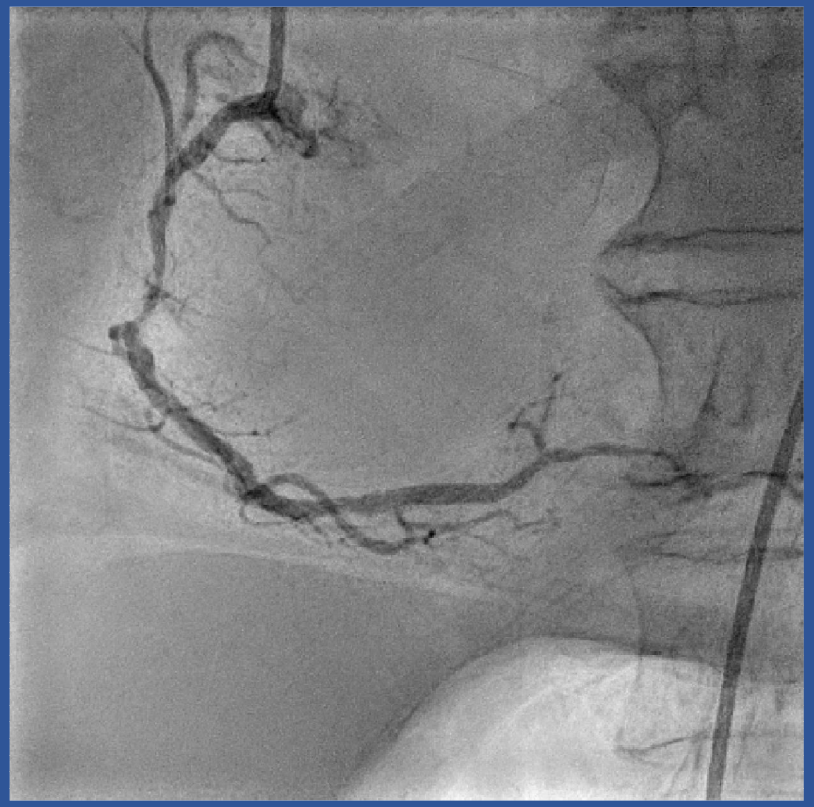
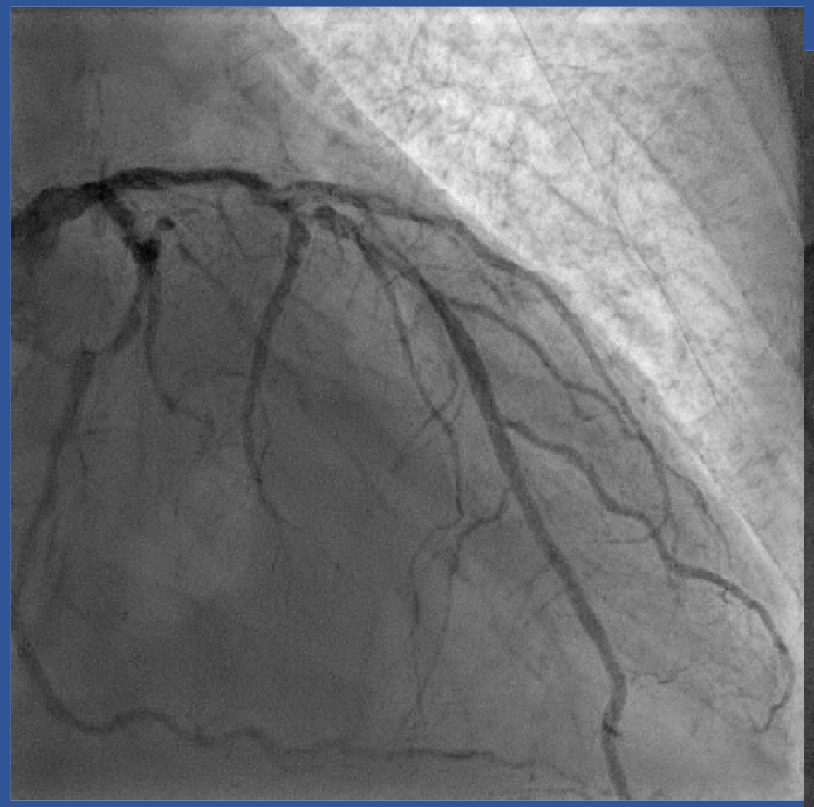
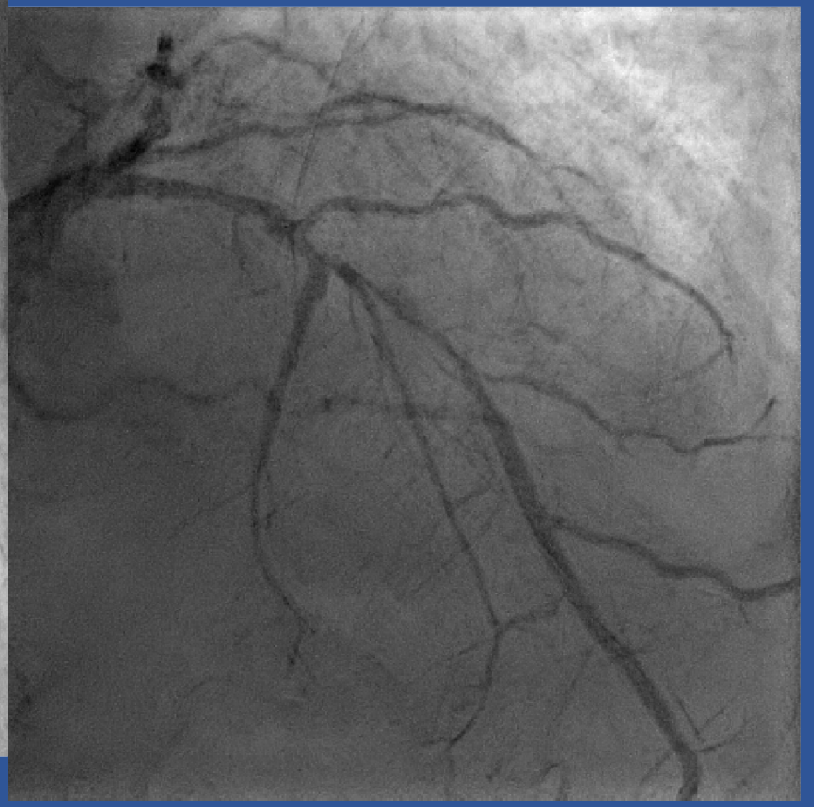
IIb	B-R	8. If triple therapy (oral anticoagulant, aspirin, and $P2Y_{12}$ inhibitor) is prescribed for patients with AF who are at increased risk of stroke (based on CHA_2DS_2-VASc risk score of 2 or greater) and who have undergone PCI with stenting (drug eluting or bare metal) for ACS, a transition to double therapy (oral anticoagulant and $P2Y_{12}$ inhibitor) at 4 to 6 weeks may be considered (S7.4-9, S7.4-10). **NEW**: New published data are available.
IIb	C	9. Administration of amiodarone or digoxin may be considered to slow a rapid ventricular response in patients with ACS and AF associated with severe LV dysfunction and HF or hemodynamic instability.
IIb	C	10. Administration of nondihydropyridine calcium antagonists may be considered to slow a rapid ventricular response in patients with ACS and AF only in the absence of significant HF or hemodynamic instability.

Synopsis

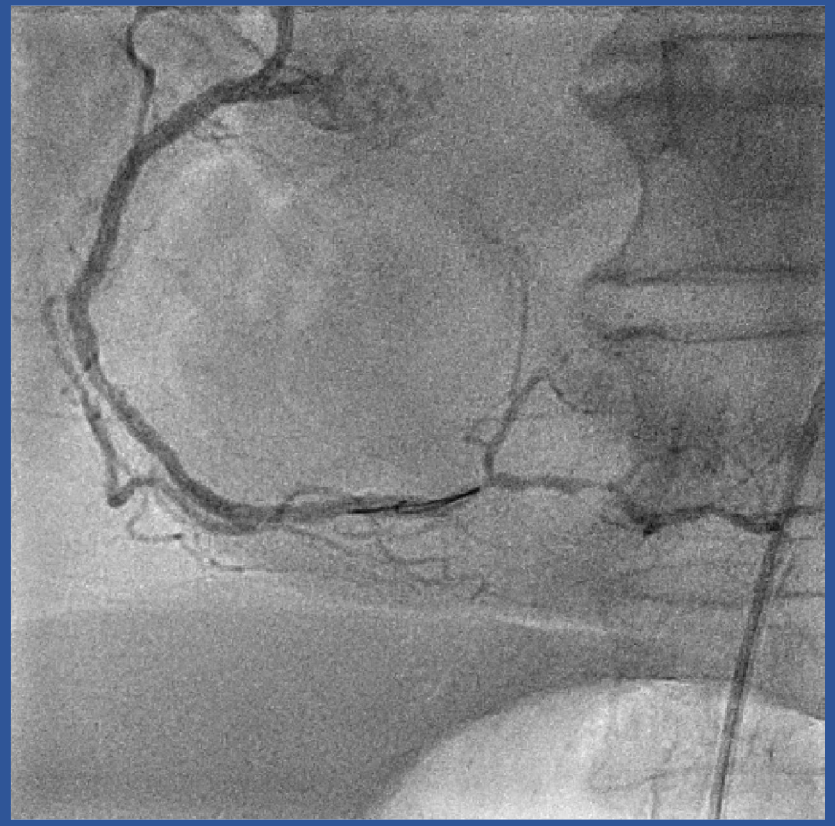
EL PACIENTE PRESENTA ENFERMEDAD SEVERA DE 3 VASOS

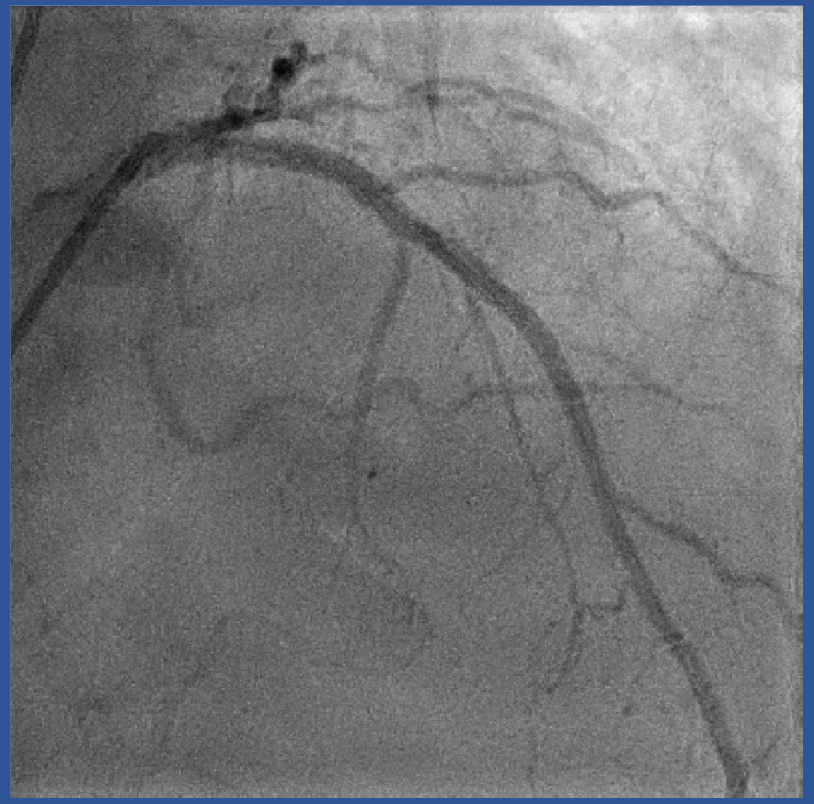






TRATAMIENTO PERCUTANEO





CD:Stent orsiro 3x30 mm

DA: 2 stents orsiro solapados 3,5x22 y 3x26

TRATAMIENTO

- Apixaban 2,5 mg/12 indefinido
- Clopidogrel 75 mg 1 año
- AAS 100 mg 3 meses
- Evolucion: No MACE ni sangrados al año.