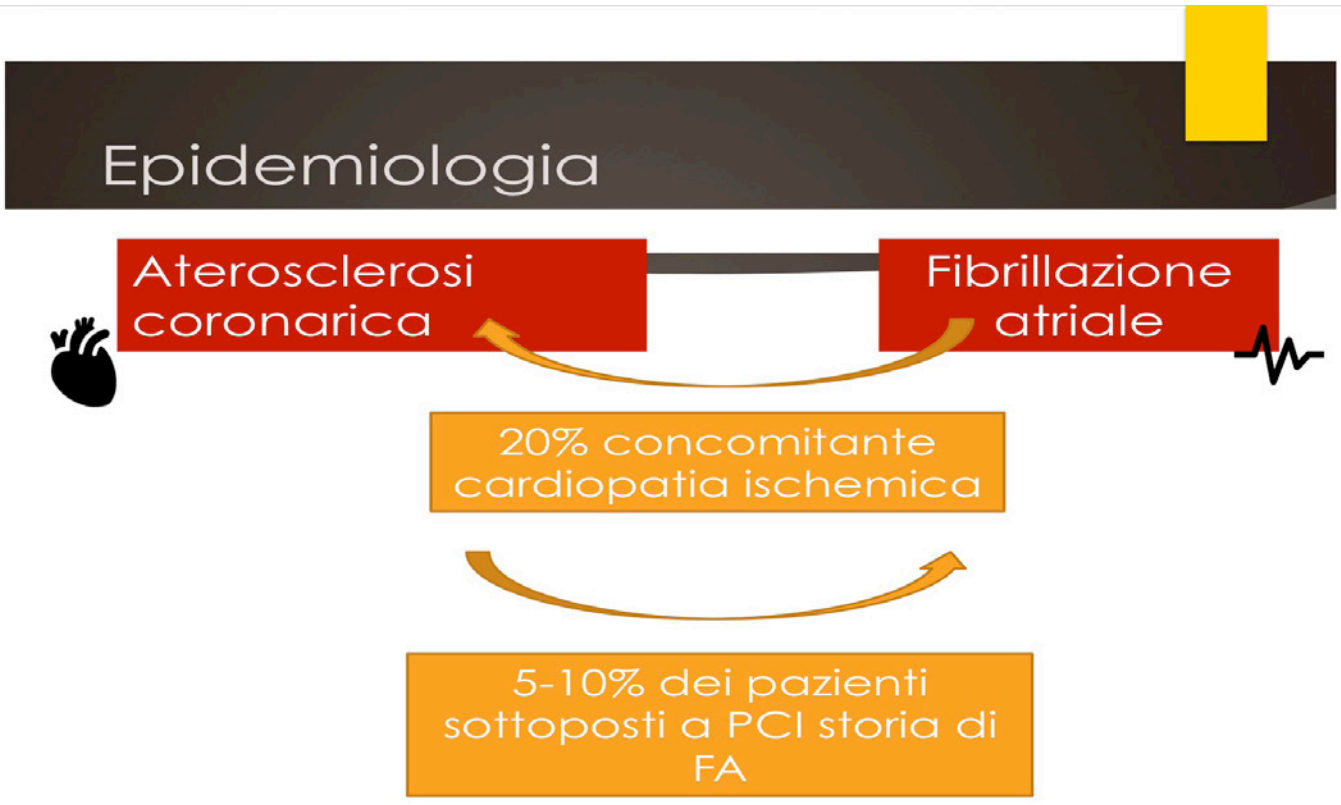
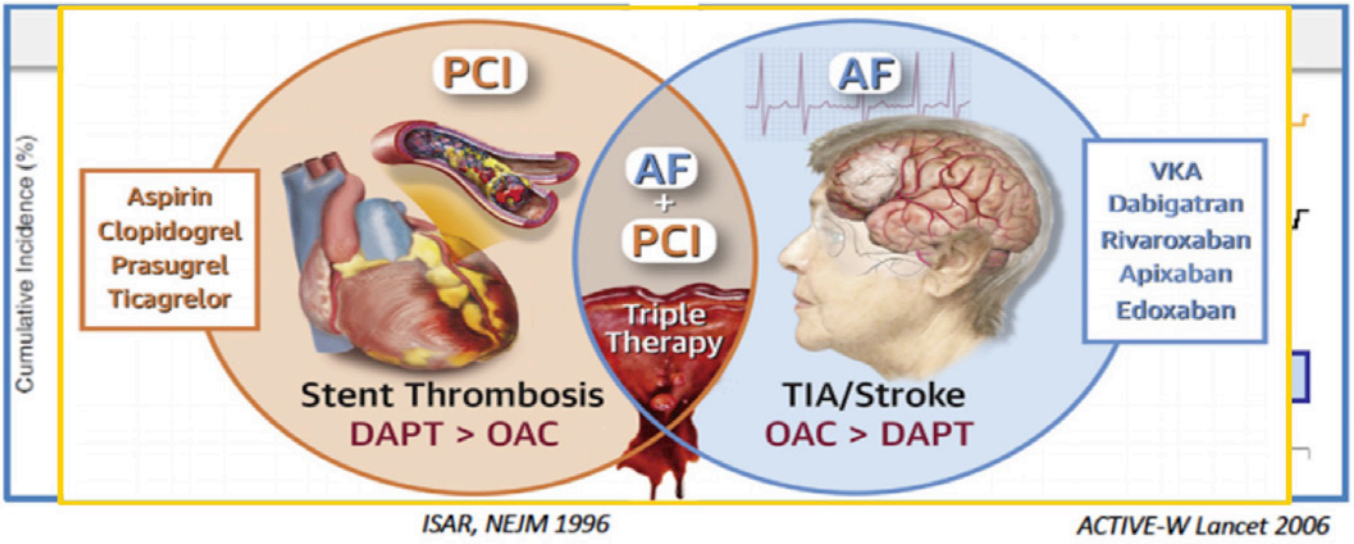
5 CONVEGNO anticoagulazione.it
Attualità cliniche e di laboratorio. Aspetti sociali
6-7 FEBBRAIO 2020
BOLOGNA Hotel Savoia Regency

Duplice/triplice trattamento antitrombotico in pazienti cin SCA e FA

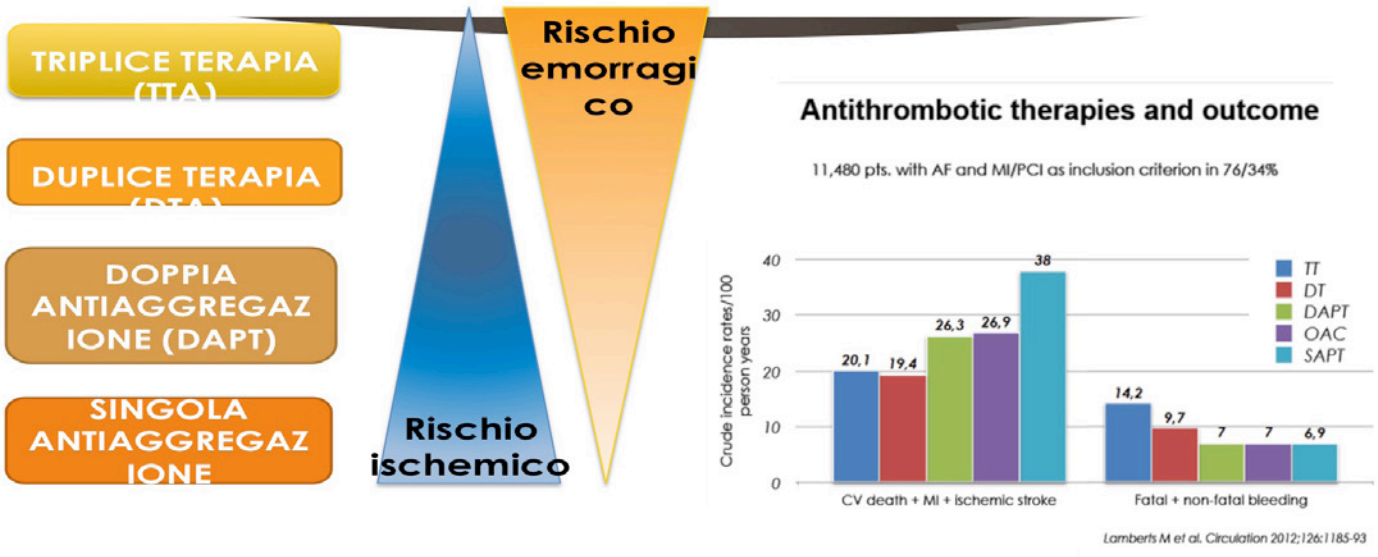
Rossella Marcucci (Firenze)



Razionale triplice terapia



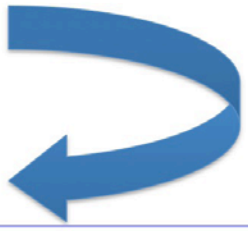
Razionale triplice terapia



↓

THE PROBLEM…..

Alternative to STANDARD TRIPLE THERAPY (TT):
AVK + ASA + Clopidogrel



Change of DRUG:

NAO vs AVK

. Augustus (apixaban)

Reduced-dose NAO vs AVK

. Pioneer (rivaroxaban)

ESC European Society of Cardiology

Europace
doi:10.1093/europace/euy174

EHRA CONSENSUS DOCUMENT

2018 EHRA, ESC WG Thrombosis, EAPCI, ACCA, HRS, APHRS, LAHRS, CASSA Consensus Document

NOACs as part of TAT or DAT are safer than VKA (e.g. Warfarin) with respect to bleeding risk and is the preferred option in the absence of contraindications to use of these drugs.

Lip GYH et al. Europace 2018

Alternative to STANDARD TRIPLE THERAPY (TT): AVK + ASA + Clopidogrel

Change of DRUG:

NAO vs AVK

. *Augustus*

Low-dose NAO vs AVK

. *Pioneer*

Change of STRATEGY:

DURATION TT

.*Isar Triple*

DUAL vs TRIPLE (~~ASA~~)

.*Woest* (AVK)

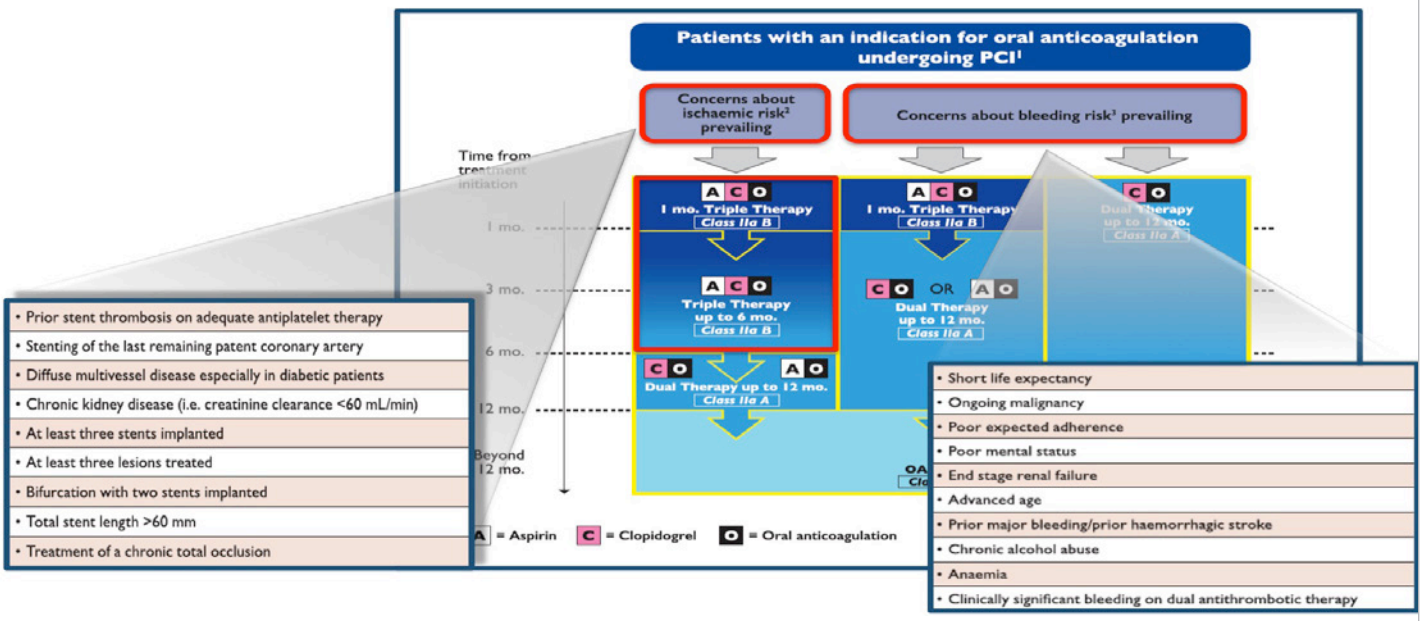
.*Pioneer* (reduced dose NAO)

.*Redual* (standard dose NAO)

.*Augustus* (standard dose NAO)

.*Entrust* (standard dose NAO)

2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS



Antithrombotic Therapy in Patients With Atrial Fibrillation Treated With Oral Anticoagulation Undergoing Percutaneous Coronary Intervention

A North American Perspective–2018 Update

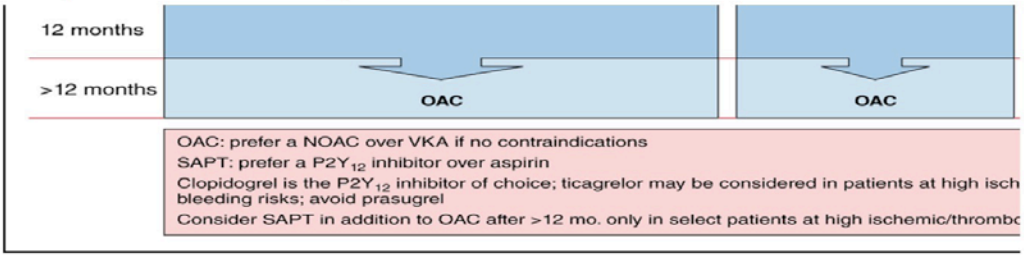
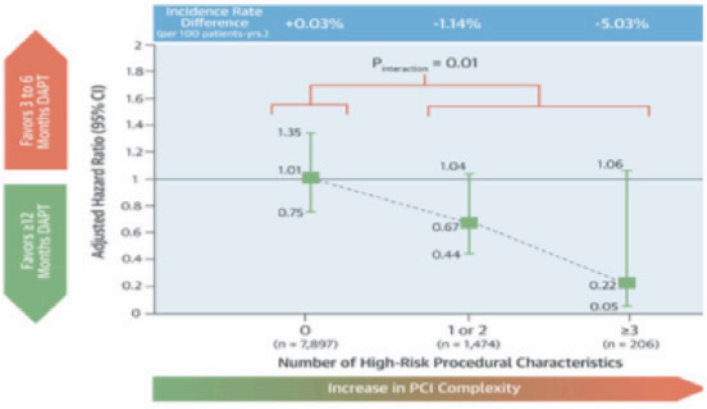


Figure 2. Management of antiplatelet therapy in patients with atrial fibrillation undergoing percutaneous an oral anticoagulant (OAC): 2018 North American expert consensus update.
A double-therapy regimen immediately after hospital discharge should be considered for most patients (default strate agulant (NOAC) should be preferred over a vitamin K antagonist (VKA) unless contraindicated. Single antiplatelet the should be started as soon as possible, including at hospital discharge. It is reasonable to extend low-dose aspirin ther PCI in selected patients at high ischemic/thrombotic and low bleeding risks. Clopidogrel remains the $P2Y_{12}$ inhibitor o selected patients, particularly those at high ischemic/thrombotic and low bleeding risks. Discontinuation of SAPT at 1 who should continue treatment on stroke-prevention doses of OAC. It is reasonable to discontinue SAPT at 6 months botic risk and those at high risk for bleeding, whereas continuation with SAPT (in addition to OAC) may be reasonabl thrombotic and low bleeding risks. DAPT indicates dual antiplatelet therapy.

CONCERNS.....

None of the RCT was powered to detect differences in ischemic outcome particularly stent thrombosis, which albeit rare, is associated with high morbidity/mortality

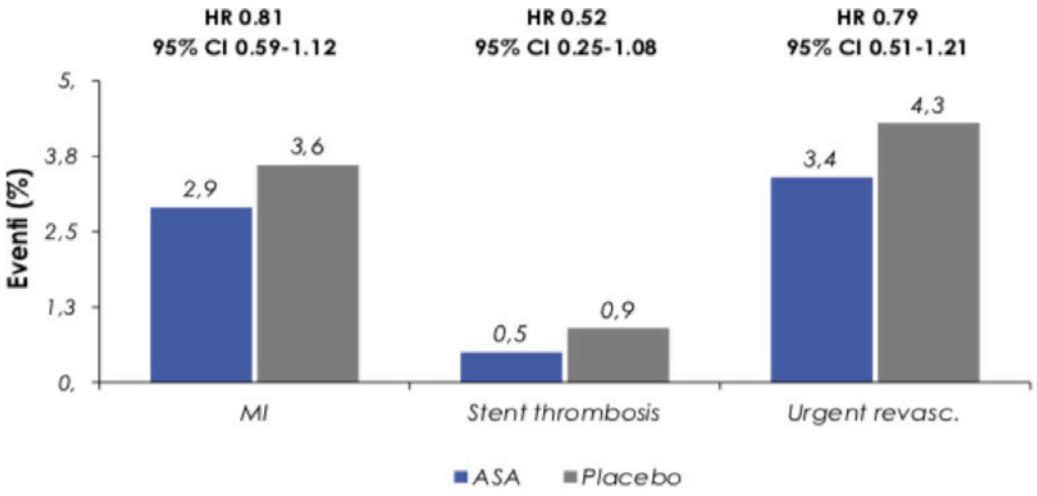
Efficacy and Safety of Dual Antiplatelet Therapy After Complex PCI



- 3 vessel treated
- ≥ 3 stents implanted
- ≥ 3 lesion treated
- Bifurcations with 2 stents
- ≥ 60 mm total stent length
- Chronic total occlusion

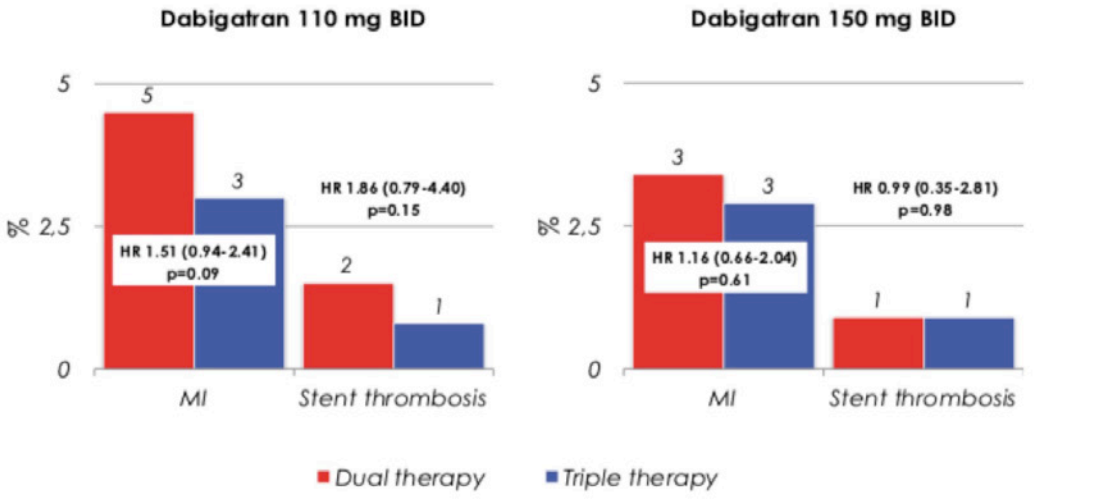
(J Am Coll Cardiol 2016;68:1851–64)

Augustus trial: coronary events



Lopes RD et al. N Engl J Med 2019;doi:10.1056/NEJMoa1817083

Re dual PCI trial: coronary events



Cannon CP et al. N Engl J Med 2017;377:1513-248

ACS vs Elective PCI
Clopidogrel vs new P2Y12 inhibitors

	PIONEER AF-PCI	REDUAL-PCI	AUGUSTUS	ENTRUST AF-PCI
NOAC	Rivaroxaban	Dabigatran	Apixaban	Edoxaban
Patients	2124	2725	4614	1500
ACS pts	1096 (51.6%)	1375 (50.5%)	ACS+PCI : 1714 (37%) Medically managed ACS: 1097 (23.9%)	777 (52%)
Ticagrelor	92 (4.3%)	327 (12%)	280 (6,2%)	106 (7.1%)
Prasugrel	28 (1.3%)	---	51 (1.1%)	8 (<1%)

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study. In contrast, ticagrelor was significantly associated with 16% *lower* risk for the primary composite outcome of cardiovascular death, myocardial infarction, or stroke, compared to clopidogrel in the aforementioned randomized PLATO trial.[27] Despite multivariable statistical adjustments, our findings may merely reflect that patients receiving ticagrelor, at the choice of the investigator, were at higher risk for thromboembolic and bleeding events, e.g. because of clinical and procedural complexity factors.

Despite the higher bleeding risk observed in patients treated with ticagrelor, the benefits of both dabigatran 110 mg and 150 mg dual therapy compared with warfarin triple therapy were consistent across the ticagrelor and clopidogrel subgroups. In patients with AF where more intensive platelet inhibition is warranted, e.g. after an ACS with high risk for new coronary events, or in patients who are non-responders to clopidogrel and thereby at high risk for thromboembolic events,[28] dabigatran dual therapy with ticagrelor might be an attractive alternative after PCI as recently suggested in a North American consensus document.[10] Notably the trend for higher risk for myocardial infarction and stent thrombosis in patients treated with dabigatran 110 mg dual therapy compared with warfarin triple therapy seemed attenuated in those patients receiving ticagrelor, with the caveat that this finding is based on a
patients.

Approximately 10% of patients in the warfarin t
received ticagrelor in combination with aspirin
present study. Albeit based on modest numbers
rates in these patients support current guideline
to avoid newer P2Y12 inhibitors as part of oral
therapy.[6,7,9,10] In addition, in previous small obse
[31] VKA or NOAC triple therapy with ticagrelor
been associated with up to three times higher risk
compared to triple therapy with clopidogrel.

This report has limitations. Subgroup ana
specified, should always be interpreted cautious
ual subgroups were not powered for formal s
each individual subgroup, and therefore the C
wider than in the main study due to the sm
patients and events, especially in the relatively
patients receiving ticagrelor. Also, interaction
regarded as exploratory. The magnitude of incr
with ticagrelor compared to clopidogrel was s
the present study than in the randomized post-A

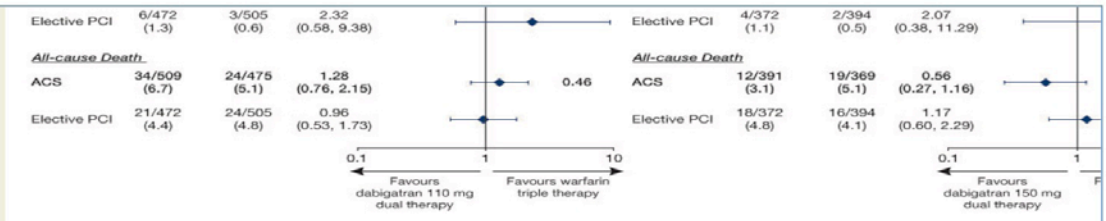
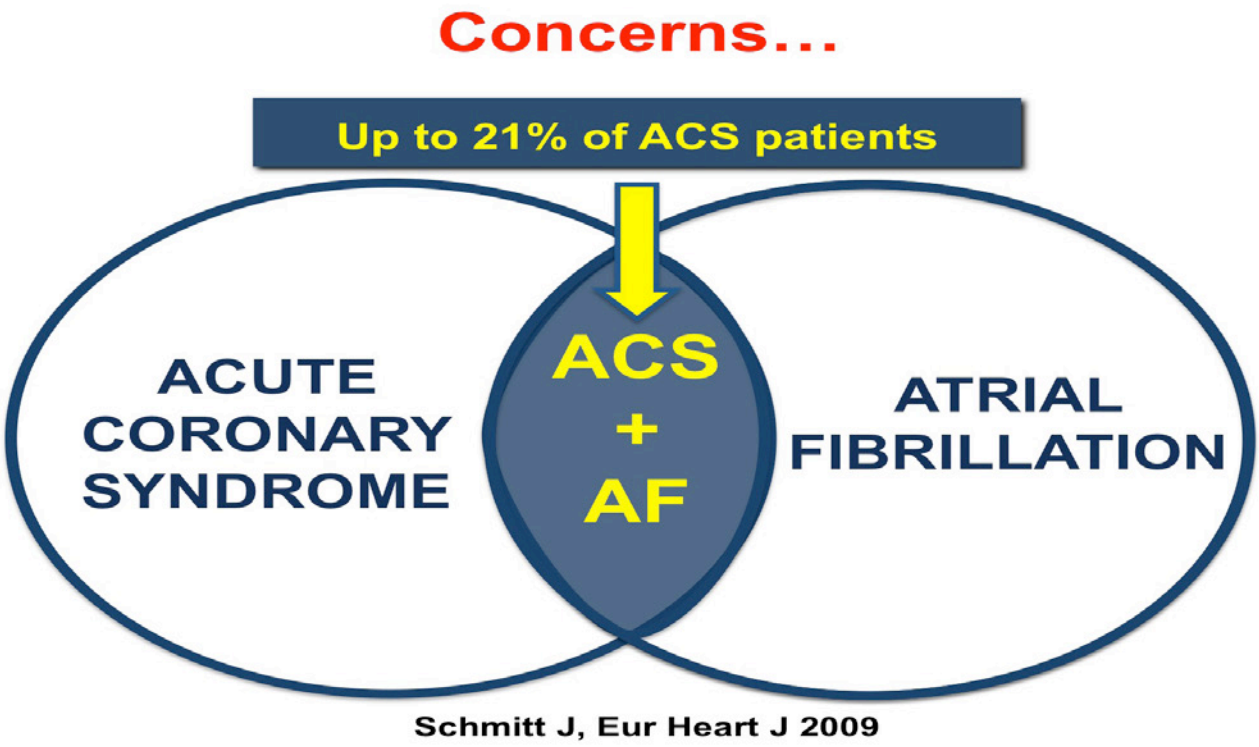


Figure 3 Death, thromboembolic events, and unplanned revascularization by percutaneous coronary intervention indication [a]From Cox proportional hazard model stratified by age (elderly vs. non-elderly). [b]For the comparison with dabigatran 150 mg dual patients outside the USA were excluded. [c]From unstratified Cox proportional hazard model. ACS, acute coronary syndrome; CI, co DTE, death or thromboembolic event (myocardial infarction, stroke, or systemic embolism); PCI, percutaneous coronary interventic

and primary safety outcome incidences. Both dabigatran dual therapies were associated with substantially reduced risk of bleeding events compared with warfarin triple therapy without signs of interaction between study treatment and the indication for PCI (ACS or elective). The risk of the composite of death, thromboembolic events, or unplanned revascularization with dabigatran dual therapies seemed comparable to warfarin triple therapy in the ACS and elective PCI subgroups. While there was substantially less bleeding with dabigatran 110 mg dual therapy compared with warfarin triple therapy, numerically higher risks of myocardial infarction and stent thrombosis were observed in the ACS population, although the number of events was small and interaction *P*-values were non-significant. These differences should be interpreted with caution as the main RE-DUAL PCI study was not adequately powered for individual thromboembolic events,

and the results in the present analysis are based on bers of patients and events within each subgroup. dabigatran doses in the dual therapy groups have pr uated for stroke prevention compared with warf RE-LY study,[26] dabigatran 150 mg was superior to w risk reduction in stroke, whereas dabigatran 110 m to warfarin for stroke prevention. Thus, irrespectiv ive PCI at the index event, dabigatran 150 mg dua tractive option after PCI in patients with AF,[9] w 110 mg dual therapy should be considered in very e those at increased bleeding risk.

In the PIONEER-AF PCI trial,[13] both dual therapy 15 mg once daily and triple therapy with rivarox daily also reduced clinically relevant bleeding even



*Corresponding author: Division of Cardiology, Ospedale San Giovanni Evangelista, Via Parrozzani, 3, 00019 Tivoli, Ro
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SUBMITTED ON 05/02/2017 - REVISION RECEIVED ON 20/03/2017 - ACCEPTE

N=1,363 pts

The cumulative incidence of NACE and MACE wa
1.7%, respectively. The incidence of NACE, MACE
adverse events in patients treated with old or novel P
tor inhibitors during the whole hospitalisation and in p
received a switch of oral antiplatelet therapies is shown

SWITCHING AND CLINICAL EVENTS AT FOLLOW-U
Clinical follow-up was completed in 1,284 (94.2%)
a mean of 42±11 days from hospital discharge. The
ferent oral antiplatelet agents in the cathlab, at disch
follow-up in NSTE-ACS and STEMI patients is c
Figure 2A and **Figure 2B.**

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teers, subjects with stable coronary artery disease a
with ACS, have shown the feasibility of both upgrad
and change[12-15]. All studies are consistent in showin
platelet inhibition when upgrade switching is achieved
pared to a higher clopidogrel maintenance dose or afte
from a high clopidogrel LD, while similar platelet i
observed when change between ticagrelor and prasu
formed[3,12,13]. Specifically designed studies evaluating e
safety with respect to clinical outcomes from the switc
$P2Y_{12}$ receptor inhibitors are not currently available
observational analyses assessing clinical outcomes
with switching from clopidogrel to novel $P2Y_{12}$ rece
tors have recently been reported[3,4,14,15]. A study-level m

464

De Luca L et al, Eurointervention 2019

TROPICAL ACS **treatment in ACS patients undergoing PCI**

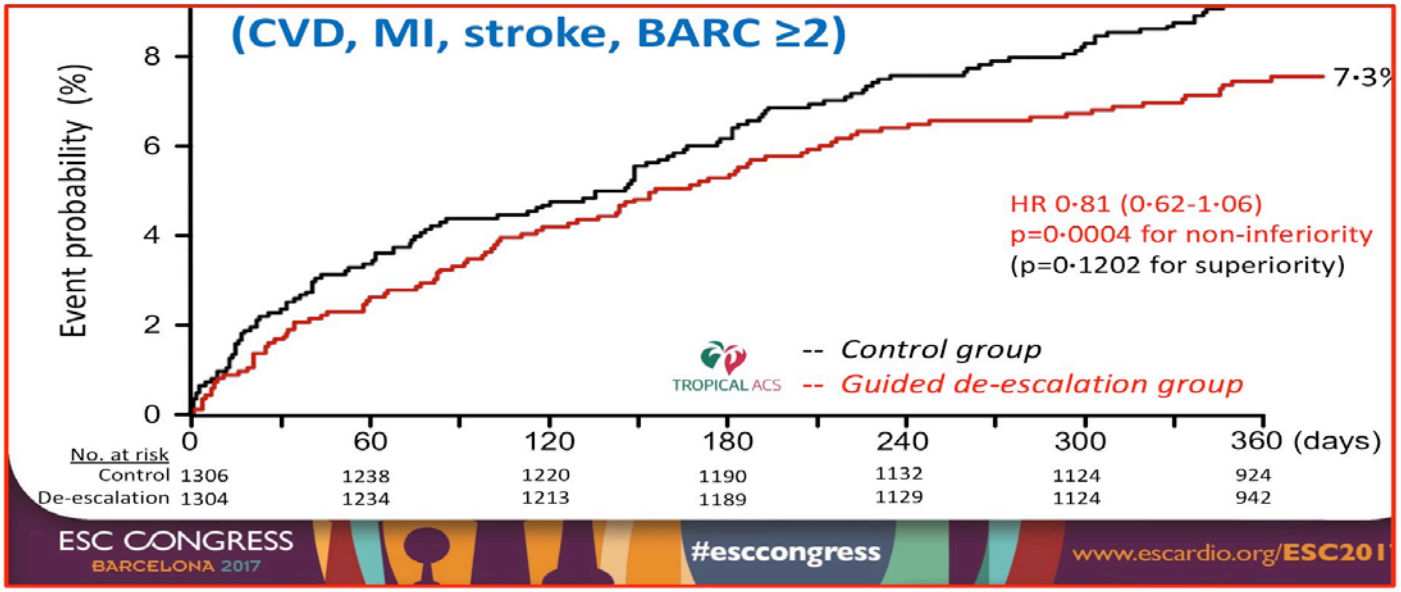
Results of the TROPICAL-ACS study: a randomised, investigator-initiated, open-label, multicentre-trial

D. Sibbing, D. Aradi, C. Jacobshagen, L. Gross, D. Trenk, F. J. Neumann, K. Huber, Z. Huczek, J. Mehilli and S. Massberg, on behalf of the TROPICAL-ACS Investigators

Munich Heart Alliance · LMU KLINIKUM DER UNIVERSITÄT MÜNCHEN · DZHK DEUTSCHES ZENTRUM FÜR HERZ-KREISLAUF-FORSCHUNG E.V.

ESC CONGRESS BARCELONA 2017 #esccongress www.escardio.org/ESC2017

Sibbing D, Lancet 2017



Sibbing D, Lancet 2017

ASSOCIAZIONE TERAPIE ANTIAGGREGANTI ed ANTICOAGULANTI

TAKE HOME MESSAGE

Il paziente con fibrillazione atriale e stenting: possiamo *veramente* evitare *subito* la triplice terapia antitrombotica nella *maggioranza* dei pazienti?

Probabilmente SI nei pazienti con FANV e PCI elettiva:

- **DUAL antithrombotic therapy**
- **NAO/clopidogrel**

Attenzione nei pazienti con ACS:

- **rinuncia a ticagrelor/prasugrel ?**
- **mantenere ASA per prime 2-4 settimane ?**
- **ticagrelor prime settimane e poi deescalation?**

Verifica inibizione funzione piastrinica