Curs d'atenció compartida en Cardiologia. Manejo intrahospitalario del SCACEST

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Conflicto de intereses

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No hay conflicto de intereses que declarar

Aspectos peri-angioplastia primaria

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Recommendations	Class	Level
Procedural aspects of primary PCI		
Stenting is recommended (over balloon angioplasty alone) for primary PCI.	I	A
Primary PCI should be limited to the culprit vessel with the exception of cardiogenic shock and persistent ischaemia after PCI of the supposed culprit lesion.	IIa	B
If performed by an experienced radial operator, radial access should be preferred over femoral access.	IIa	B
If the patient has no contraindications to prolonged DAPT (indication for oral anticoagulation, or estimated high long-term bleeding risk) and is likely to be compliant, DES should be preferred over BMS.	IIa	A
Routine thrombus aspiration should be considered.	IIa	B
Routine use of distal protection devices is not recommended.	III	C
Routine use of IABP (in patients without shock) is not recommended.	III	A

BMS = bare-metal stent; DAPT = dual antiplatelet therapy; DES = drug-eluting stent; IABP = intra-aortic balloon pump; PCI = percutaneous coronary intervention.

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European Heart Journal 2012 - doi:10.1093/eurheartj/ehs215

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Recomendaciones en PCR

Recommendations	Class	Level
All medical and paramedical personnel caring for a patient with suspected myocardial infarction must have access to defibrillation equipment and be trained in cardiac life support.	I	C
It is recommended to initiate ECG monitoring at the point of FMC in all patients with suspected myocardial infarction.	I	C
Therapeutic hypothermia is indicated early after resuscitation of cardiac arrest patients who are comatose or in deep sedation.	I	B
Immediate angiography with a view to primary PCI is recommended in patients with resuscitated cardiac arrest whose ECG shows STEMI.	I	B
Immediate angiography with a view to primary PCI should be considered in survivors of cardiac arrest without diagnostic ECG ST-segment elevation but with a high suspicion of ongoing infarction.	IIa	B

ECG = electrocardiogram; FMC = first medical contacts; PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.

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Antitrombóticos en la ACTP primaria

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Recommendations	Class	Level
Antiplatelet therapy		
Aspirin oral or i.v. (if unable to swallow) is recommended	I	B
An ADP-receptor blocker is recommended in addition to aspirin. Options are:	I	A
• Prasugrel in clopidogrel-naive patients, if no history of prior stroke/TIA, age < 75 years.	I	B
• Ticagrelor.	I	B
• Clopidogrel, preferably when prasugrel or ticagrelor are either not available or contraindicated.	I	C
GP IIb/IIIa inhibitors should be considered for bailout therapy if there is angiographic evidence of massive thrombus, slow or no-reflow or a thrombotic complication.	IIa	C

ADP = adenosine diphosphate.

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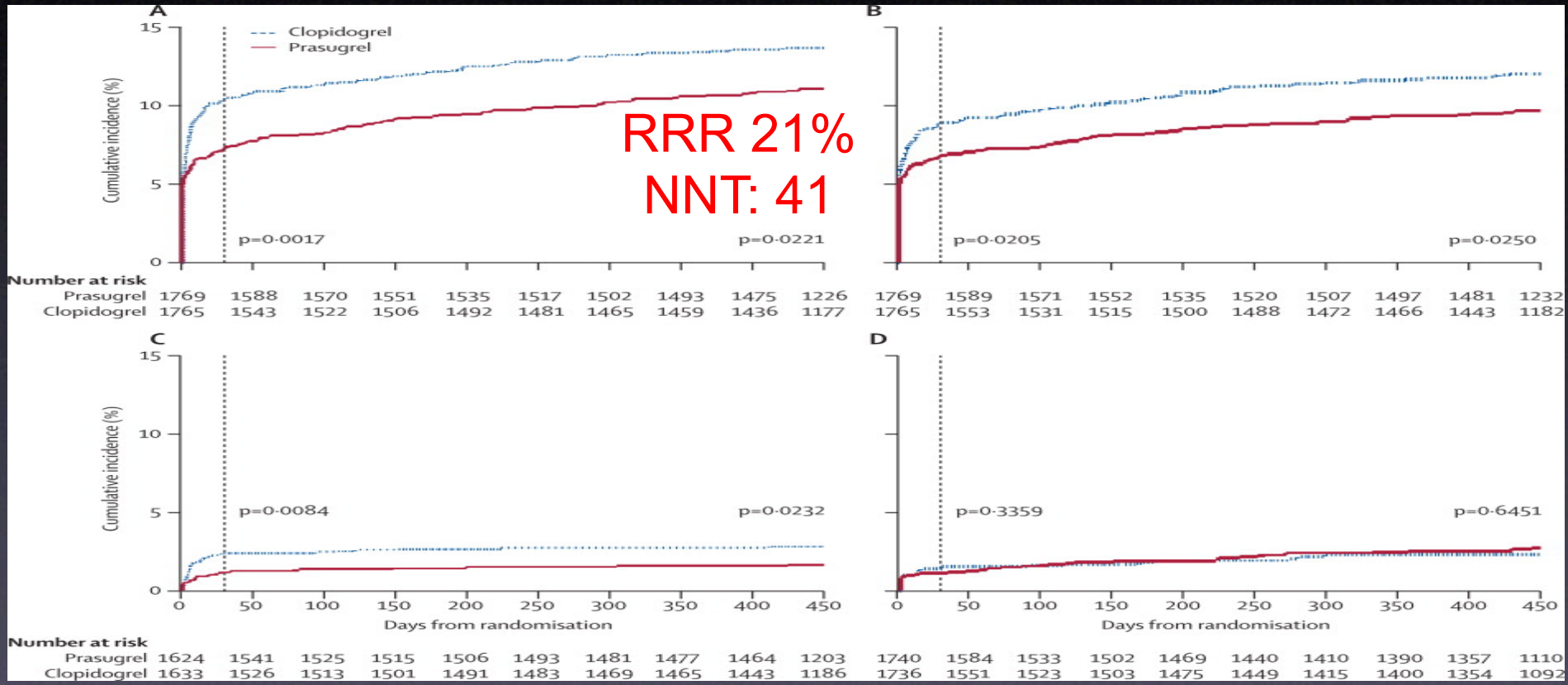
Antitrombóticos en la ACTP primaria

- Triton-TIMI 38: Prasugrel 60 mg+ 10mg/d vs Clopidogrel 300 mg + 75 mg/d
- N= 3534



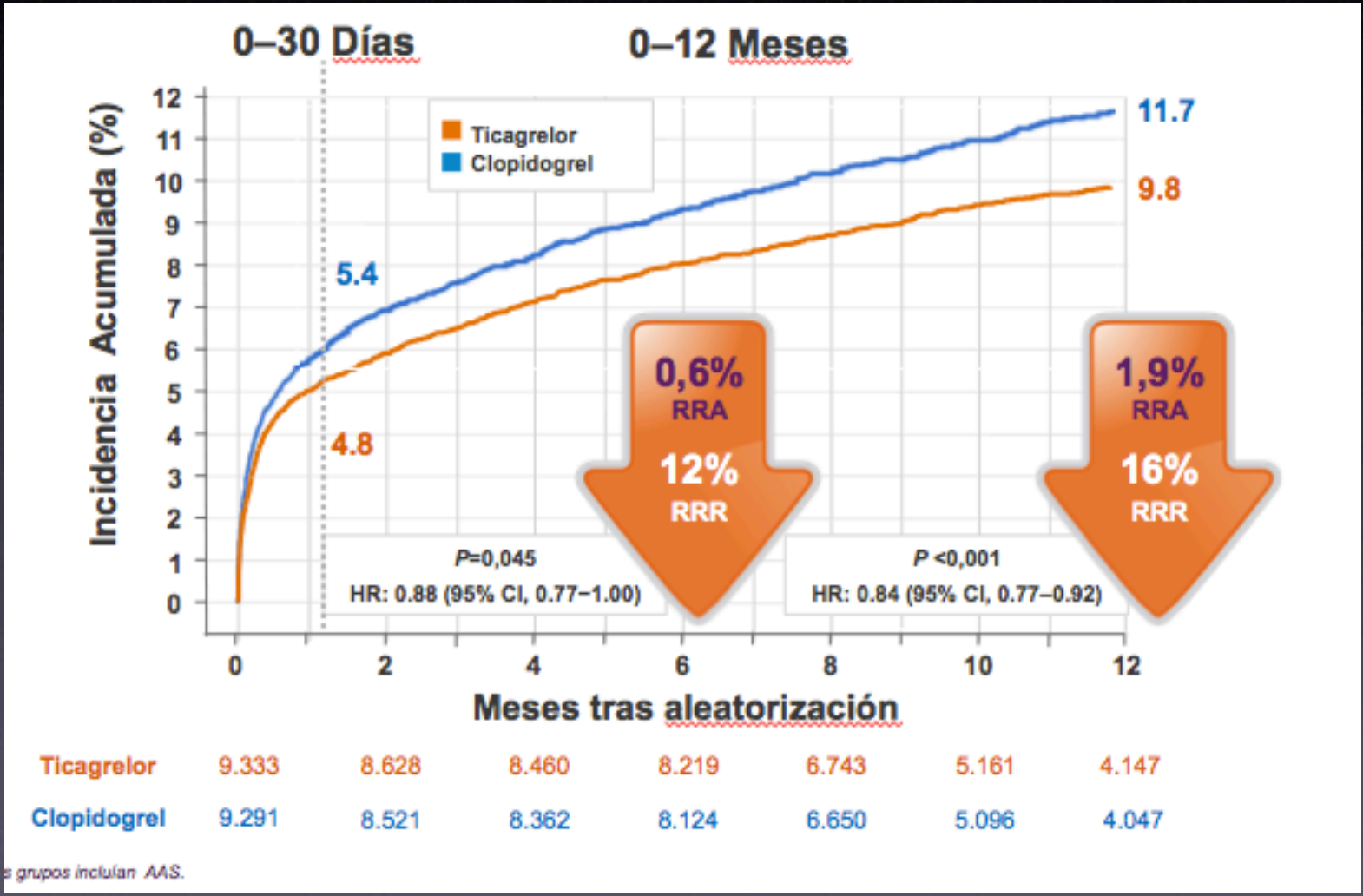
Curvas de Kaplan-Meier curves para: (A) Objetivo primario (Muerte, IAM no fatal, AVC no fatal (B) Objetivo secundario (muerte, IAM, nec revasc; (C) trombosis del stent; (D) sangrado mayor

- Exceso de sangrado en peso<60 kg, edad>75ª, AVC previo y en pacientes sometidos a cirugía.

Montalescot et al. Lancet 2009;373:723-31

Antitrombóticos en la ACTP primaria

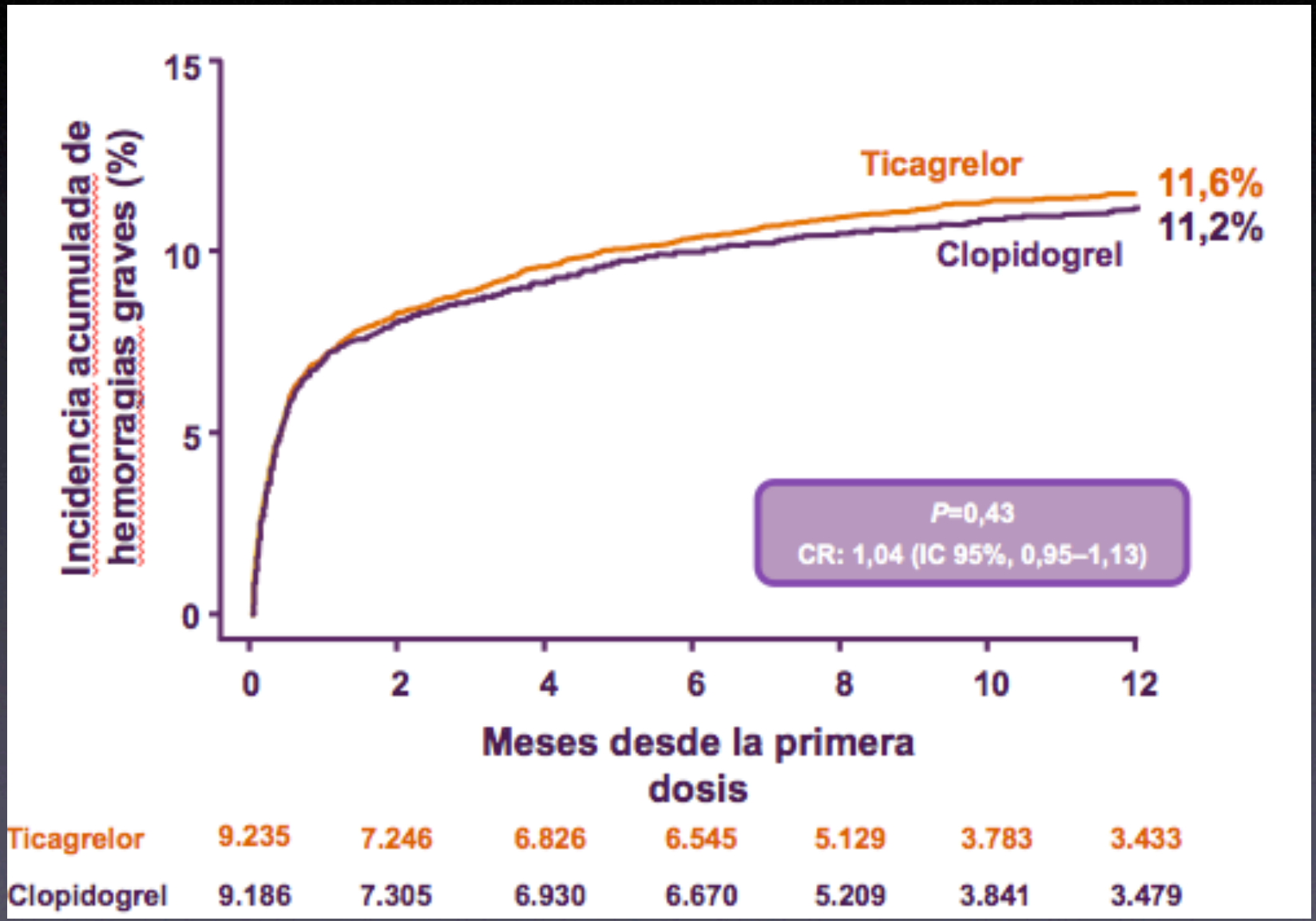
- Plato: Ticagrelor 180 mg+ 90mg/12hs vs Clopidogrel 300/600 mg + 75 mg/d
- N= 18624 (6908 SCACEST)



Curvas de Kaplan-Meier para objetivo combinado de muerte, IAM y AVC no fatal

Wallentin L, et al. *N Engl J Med*. 2009;361:1045–57.

Antitrombóticos en la ACTP primaria



Curvas de Kaplan-Meier para objetivo de seguridad: sangrado mayor total

Wallentin L, et al. N Engl J Med. 2009;361:1045–57.

Estimación del riesgo de hemorragia

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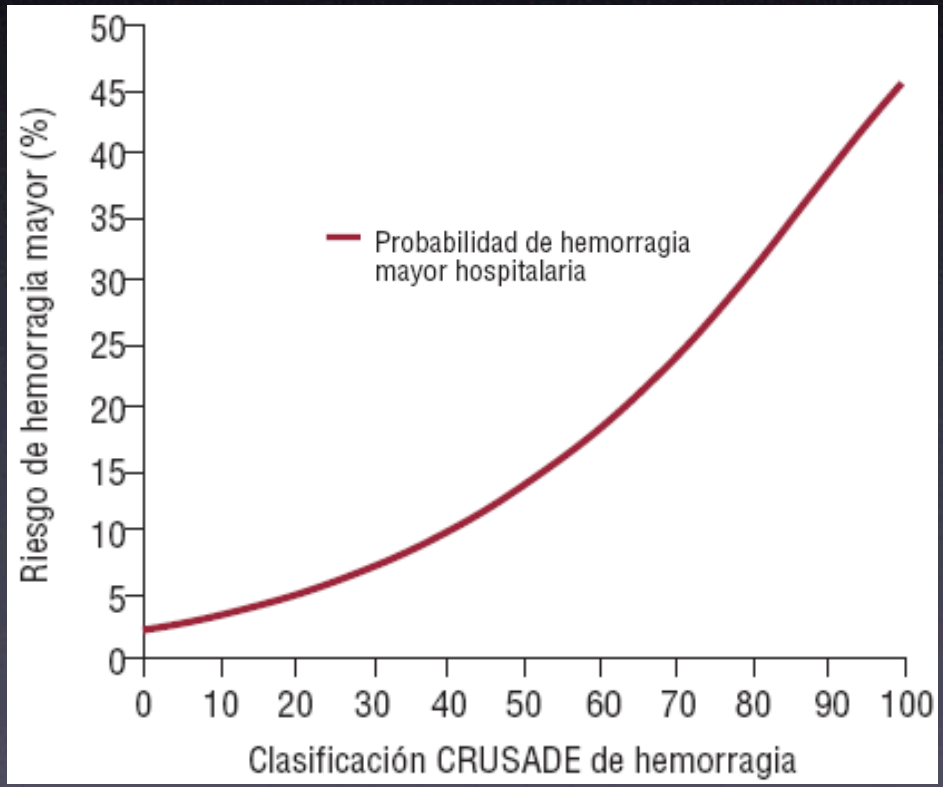
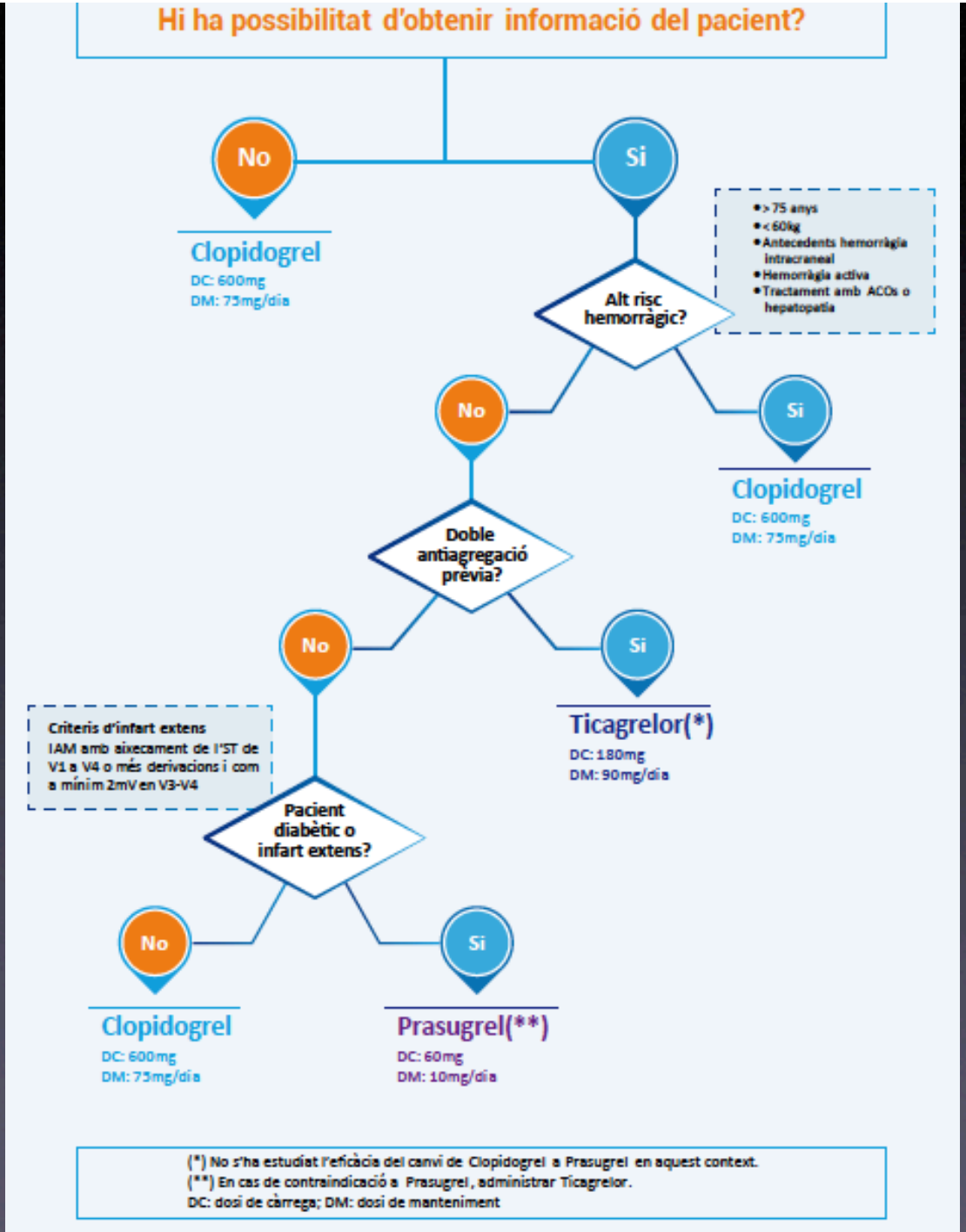
Riesgo de hemorragia mayor según la clasificación CRUSADE



Predictor	Puntuación
Hematocrito basal (%)	
< 31	9
31-33,9	7
34-36,9	3
37-39,9	2
≥ 40	0
Aclaramiento de creatinina[a] (ml/min)	
≤ 15	39
> 15-30	35
> 30-60	28
> 60-90	17
> 90-120	7
> 120	0
Frecuencia cardiaca (lpm)	
≤ 70	0
71-80	1
81-90	3
91-100	6
101-110	8
111-120	10
≥ 121	11
Sexo	
Varón	0
Mujer	8
Signos de insuficiencia cardiaca en el momento del contacto con el médico	
No	0
Sí	7
Enfermedad vascular previa[b]	
No	0
Sí	6
Diabetes mellitus	
No	0
Sí	6
Presión arterial sistólica (mmHg)	
≤ 90	10
91-100	8
101-120	5
121-180	1
181-200	3
≥ 201	5

Subherval S, et al. Circulation 2009;119(14):1873-82.
Christian W. Hamm, et al. Rev Esp Cardiol. 2012;65(2):173.e1-e55
http://www.crusadebleedingscore.org/index.html


Hi ha possibilitat d'obtenir informació del pacient?
No
Si
Clopidogrel
DC: 600mg
DM: 75mg/dia
Alt risc hemorràgic?
•>75 anys
•<60kg
•Antecedents hemorràgia intracraneal
•Hemorràgia activa
•Tractament amb ACOs o hepatopatia
No
Si
Clopidogrel
DC: 600mg
DM: 75mg/dia
Doble antiagregació prèvia?
No
Si
Ticagrelor(*)
DC: 180mg
DM: 90mg/dia
Criteris d'infart extens
IAM amb aixecament de l'ST de V1 a V4 o més derivacions i com a mínim 2mV en V3-V4
Pacient diabètic o infart extens?
No
Si
Clopidogrel
DC: 600mg
DM: 75mg/dia
Prasugrel(**)
DC: 60mg
DM: 10mg/dia
(*) No s'ha estudiat l'eficàcia del canvi de Clopidogrel a Prasugrel en aquest context.
(**) En cas de contraindicació a Prasugrel, administrar Ticagrelor.
DC: dosi de càrrega; DM: dosi de manteniment

Routine therapies in the acute, subacute and long term phase of STEMI

Recommendations	Class	Level
Oral treatment with beta-blockers should be considered during hospital stay and continued thereafter in all STEMI patients without contra-indications.	IIa	B
Oral treatment with beta-blockers is indicated in patients with heart failure or LV dysfunction.	I	A
Intravenous beta-blockers must be avoided in patients with hypotention or heart failure.	III	B
Intravenous beta-blockers should be considered as the time of presentation in patients without contraindications, with high blood pressure, tachycardia and no signs of heart failure.	IIa	B
A fasting lipid profile must be obtained in all STEMI patients, as soos as possible after presentation.	I	C
It is recommended to initiate or continue high dose statins early after admission in all STEMI patients without contraindication or history of intolerance, regardless of initial cholesterol values.	I	A

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Routine therapies in the acute, subacute and long term phase of STEMI

Recommendations	Class	Level
Reassessment of LDL-cholesterol should be considered after 4-6 weeks to ensure that a target value of ≤1.8 mmol/L (70 mg/dL) has been reached.	IIa	C
Verapamil may be considered for secondary prevention in patients with absolute contraindications to beta-blockers and no heart failure.	IIb	B
ACE Inhibitors are indicated starting within the first 24 h of STEMI in patients with evidence of heart failure, LV systolic dysfunction, diabetes or an anterior infarct.	I	A
An ARB, preferably valsartan, is an alternative to ACE inhibitors in patients with heart failure or LV systolic dysfunction, particularly those who are intolerant to ACE inhibitors.	I	B
ACE inhibitors should be considered in all patients in the absence of contraindications.	IIa	A
Aldosterone antagonists, e.g. eplerenone, are indicated in patients with an ejection fraction ≤ 40% and heart failure or diabetes, provided no renal failure or hyperkalaemia.	I	B

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