A.C.C.A.

Amicale des Cardiologues de la Côte d'Azur

LA JOURNEE D' ACTUALITESTHERAPEUTIQUES 2018

Que faire au-delà de un an ?

Dr Laurent Drogoul
Saint Laurent Du Var

ARNAULT TZANCK

Conflits d’intérêts.

Medtronic : Proctoring TAVI
Abbott : proctoring CTO
Biosensor : proctoring CTO

Recommandations

Population	ESC Guidelines	ACCF/AHA/SCAI Guidelines
Acute Coronary Syndrome (BMS or DES)	**Maximum of 12 months (Class I-A)** **Longer durations may be considered (Class IIb-A)**	**At least 12 months (Class I-B)** **Longer durations may be considered in pts w/ DES (Class IIb-C)**
Stable Ischemia and BMS	At least 1 month (Class I-A)	At least 1 month, ideally up to 12 months (Class I-B)
Stable Ischemia and DES	6 months (Class I-B)	At least 12 months (Class I-B)
Secondary Prevention	**Selected patients at high ischemic risk**	**May be considered (Class IIb-B)**

Pourquoi ce sujet ?

Tendance actuelle :

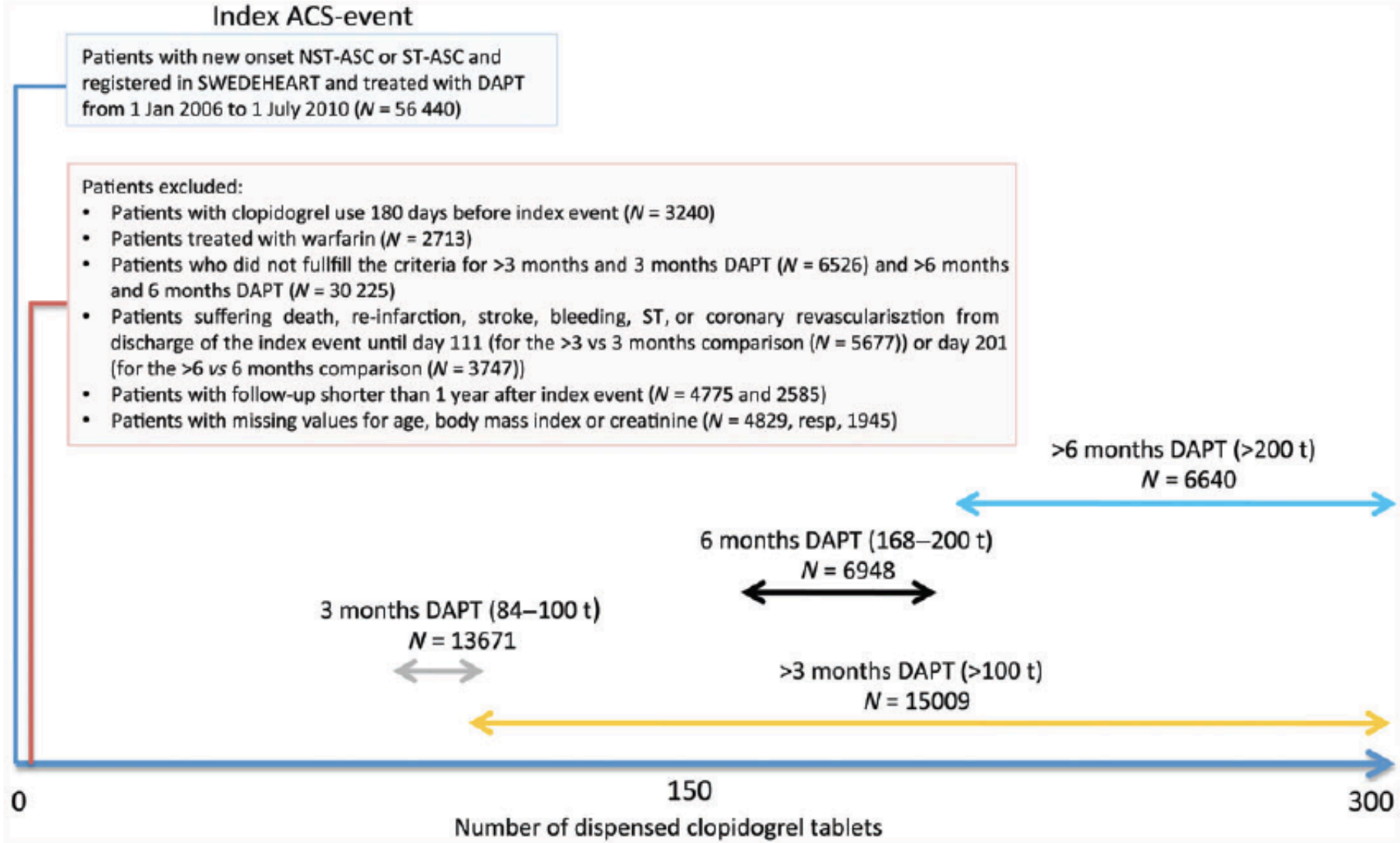
essayer de diminuer durée double AAP….

Stent actifs toutes indications…

European Heart Journal (2014) **35**, 969–978
doi:10.1093/eurheartj/eht438

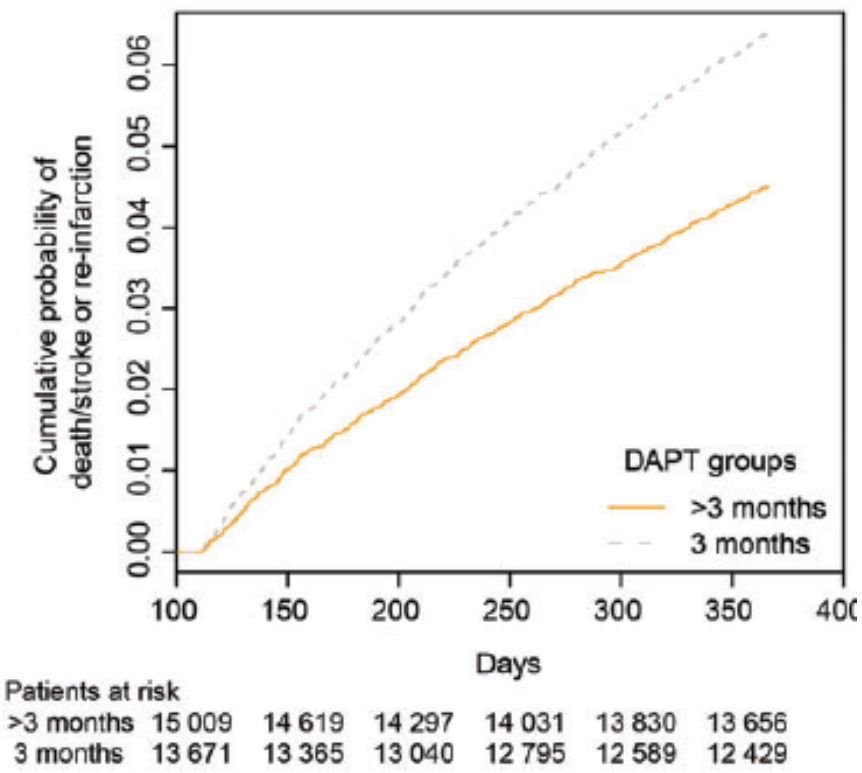
Duration of dual antiplatelet treatment with clopidogrel and aspirin in patients with acute coronary syndrome

Christoph Varenhorst[1]*, Karin Jensevik[2], Tomas Jernberg[3], Anders Sundström[4], Pål Hasvold[5,6], Claes Held[1], Bo Lagerqvist[1], and Stefan James[1]

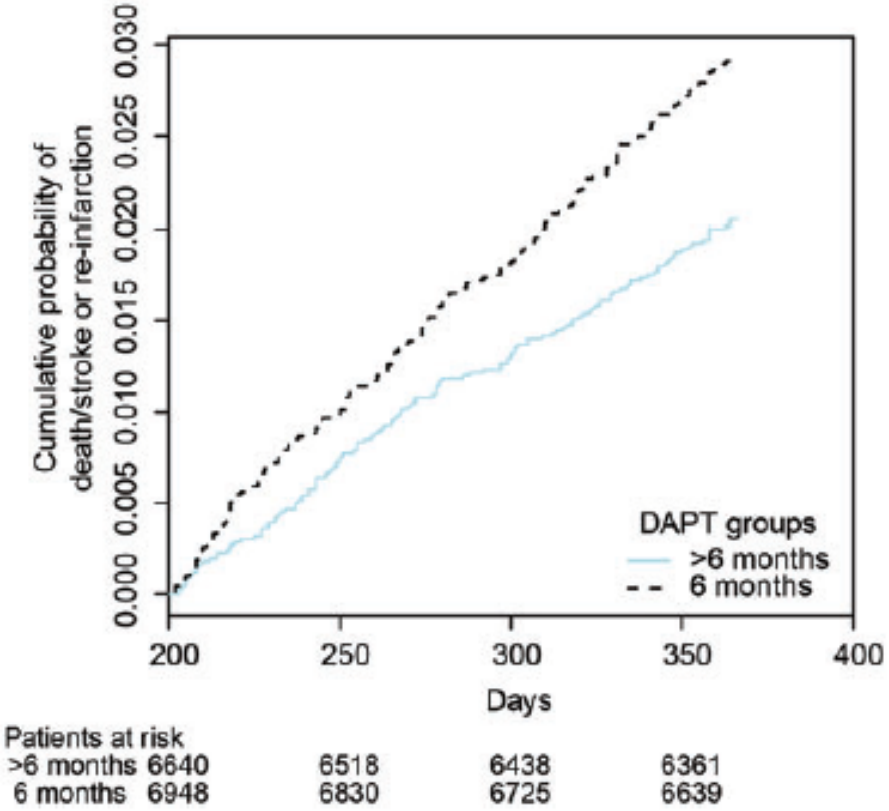

Index ACS-event
Patients with new onset NST-ASC or ST-ASC and registered in SWEDEHEART and treated with DAPT from 1 Jan 2006 to 1 July 2010 (N = 56 440)
Patients excluded:
• Patients with clopidogrel use 180 days before index event (N = 3240)
• Patients treated with warfarin (N = 2713)
• Patients who did not fullfill the criteria for >3 months and 3 months DAPT (N = 6526) and >6 months and 6 months DAPT (N = 30 225)
• Patients suffering death, re-infarction, stroke, bleeding, ST, or coronary revascularisztion from discharge of the index event until day 111 (for the >3 vs 3 months comparison (N = 5677)) or day 201 (for the >6 vs 6 months comparison (N = 3747))
• Patients with follow-up shorter than 1 year after index event (N = 4775 and 2585)
• Patients with missing values for age, body mass index or creatinine (N = 4829, resp, 1945)
>6 months DAPT (>200 t)
N = 6640
6 months DAPT (168–200 t)
N = 6948
3 months DAPT (84–100 t)
N = 13671
>3 months DAPT (>100 t)
N = 15009
0
150
300
Number of dispensed clopidogrel tablets

Evènements DC/AVC/IDM

3 mois vs > 3 mois

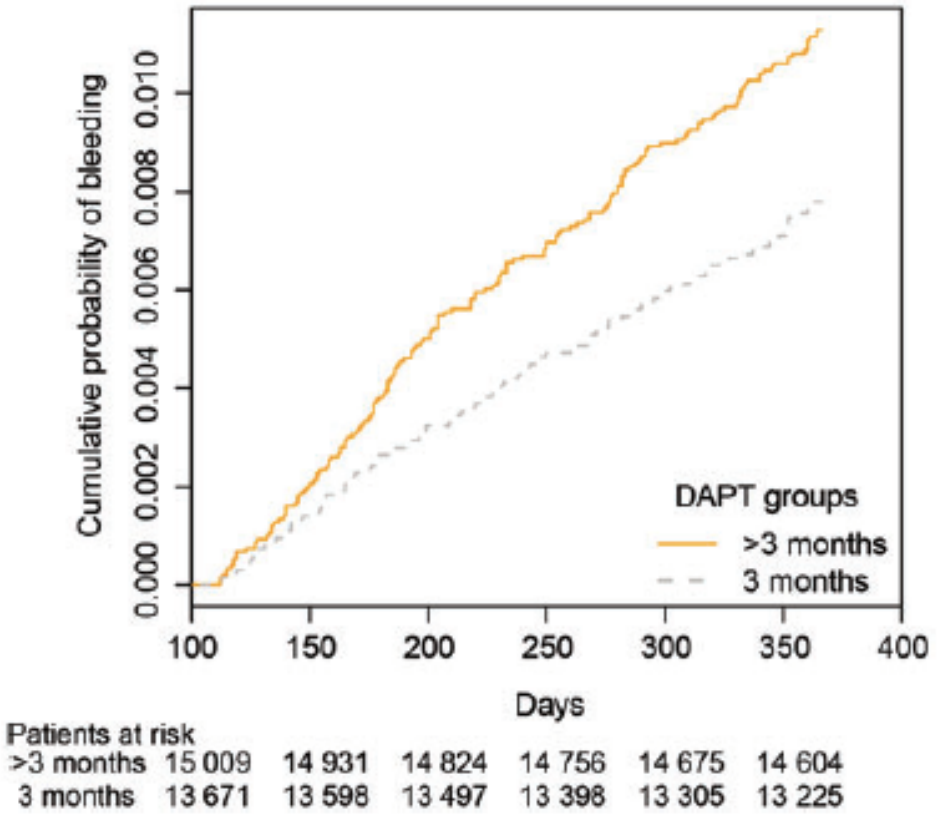


6 mois vs > 6 mois



Saignements

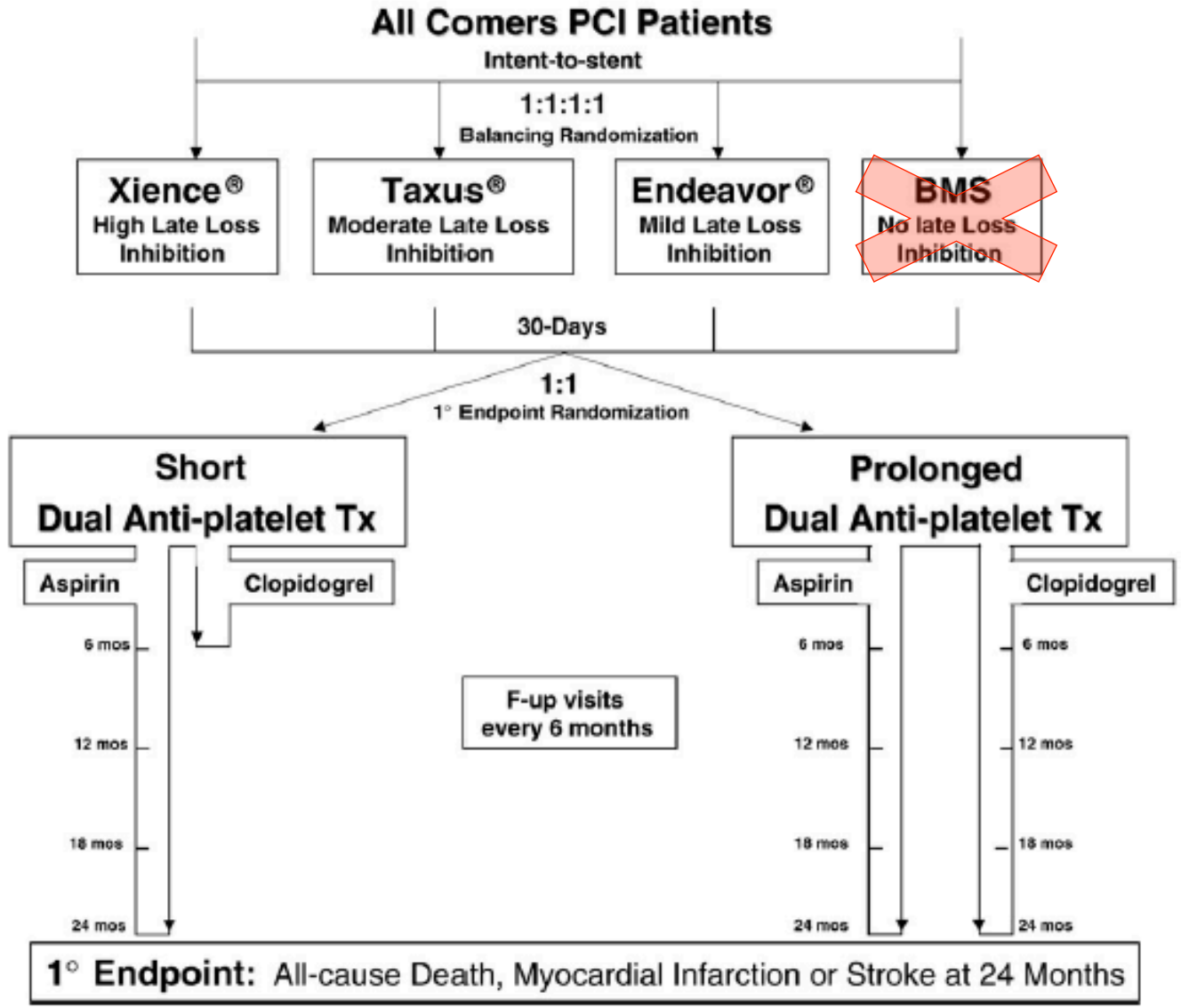
3 mois vs > 3 mois



Randomized comparison of 6- versus 24-month clopidogrel therapy after balancing anti-intimal hyperplasia stent potency in all-comer patients undergoing percutaneous coronary intervention: Design and rationale for the PROlonging Dual-antiplatelet treatment after Grading stent-induced Intimal hyperplasia study (PRODIGY)

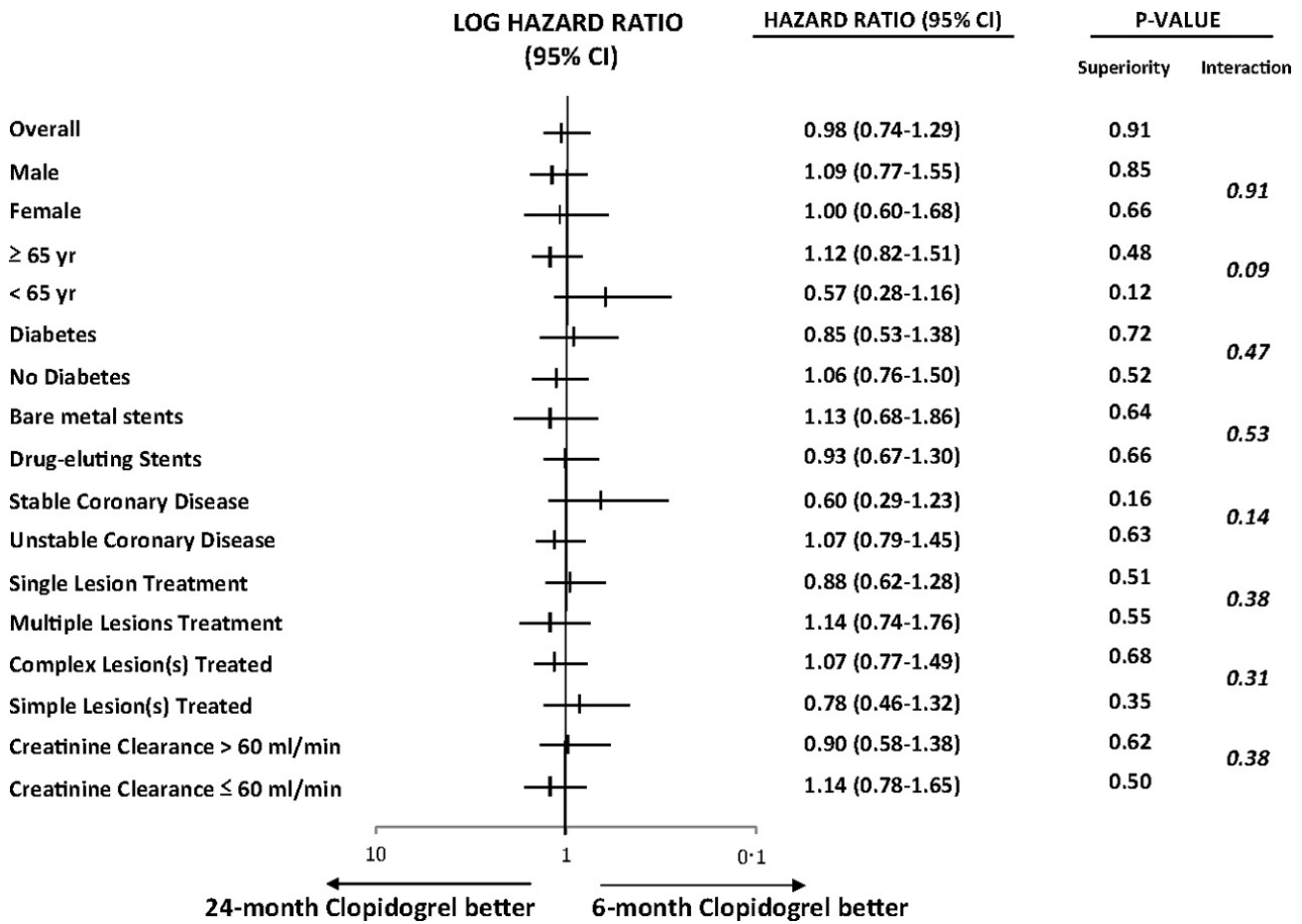
Marco Valgimigli, MD, PhD,[a,b] Gianluca Campo, MD,[a] Gianfranco Percoco, MD,[c] Monia Monti, BSc,[d] Fabrizio Ferrari, MD,[a] Carlo Tumscitz, MD,[a] Andrea Zuffi, MD,[c] Federico Colombo, MD,[c] Moh'd Kubbajeh, MD,[c] Caterina Cavazza, MD,[a] Elisa Cangiano, MD,[a] Matteo Tebaldi, MD,[a] Monica Minarelli, MD,[a] Chiara Arcozzi, MD,[a] Antonella Scalone, MD,[a] Alice Frangione, MD,[c] Marco Borghesi, MD,[a] Jlenia Marchesini, MD,[a] Giovanni Parrinello, PhD,[f] and Roberto Ferrari, MD, PhD[a,b] *Ferrara, Gussago, Valle Oppio (Comacchio), Cotignola (RA), and Brescia, Italy*

AHJ 2010


All Comers PCI Patients
Intent-to-stent
1:1:1:1
Balancing Randomization
Xience®
High Late Loss Inhibition
Taxus®
Moderate Late Loss Inhibition
Endeavor®
Mild Late Loss Inhibition
BMS
No late Loss Inhibition
30-Days
1:1
1° Endpoint Randomization
Short
Dual Anti-platelet Tx
Aspirin
Clopidogrel
6 mos
12 mos
18 mos
24 mos
F-up visits every 6 months
Prolonged
Dual Anti-platelet Tx
Aspirin
Clopidogrel
6 mos
12 mos
18 mos
24 mos
1° Endpoint: All-cause Death, Myocardial Infarction or Stroke at 24 Months

Implanted stent type, n (%)		
Bare-metal stent	246 (24.9)	246 (25.0)
Everolimus-eluting stent	248 (25.1)	245 (24.9)
Paclitaxel-eluting stent	245 (24.8)	245 (24.9)
Everolimus-eluting stent	248 (25.1)	247 (25.1)

Subgroup analyses of the primary end point.



Critères de sécurité en %	24 mois de clopidogrel	6 mois de clopidogrel	Risque relatif p
Saignement 2,3 ou 5 BARC	7,4	3,5	0,00018
Saignement 5 ou 3	3,4	1,9	0,037
Saignements 2 ou 3	6,5	3	0,00033
Saignements majeurs selon TIMI	1,6	0,6	0,041
transfusion	2,6	1,3	0,041

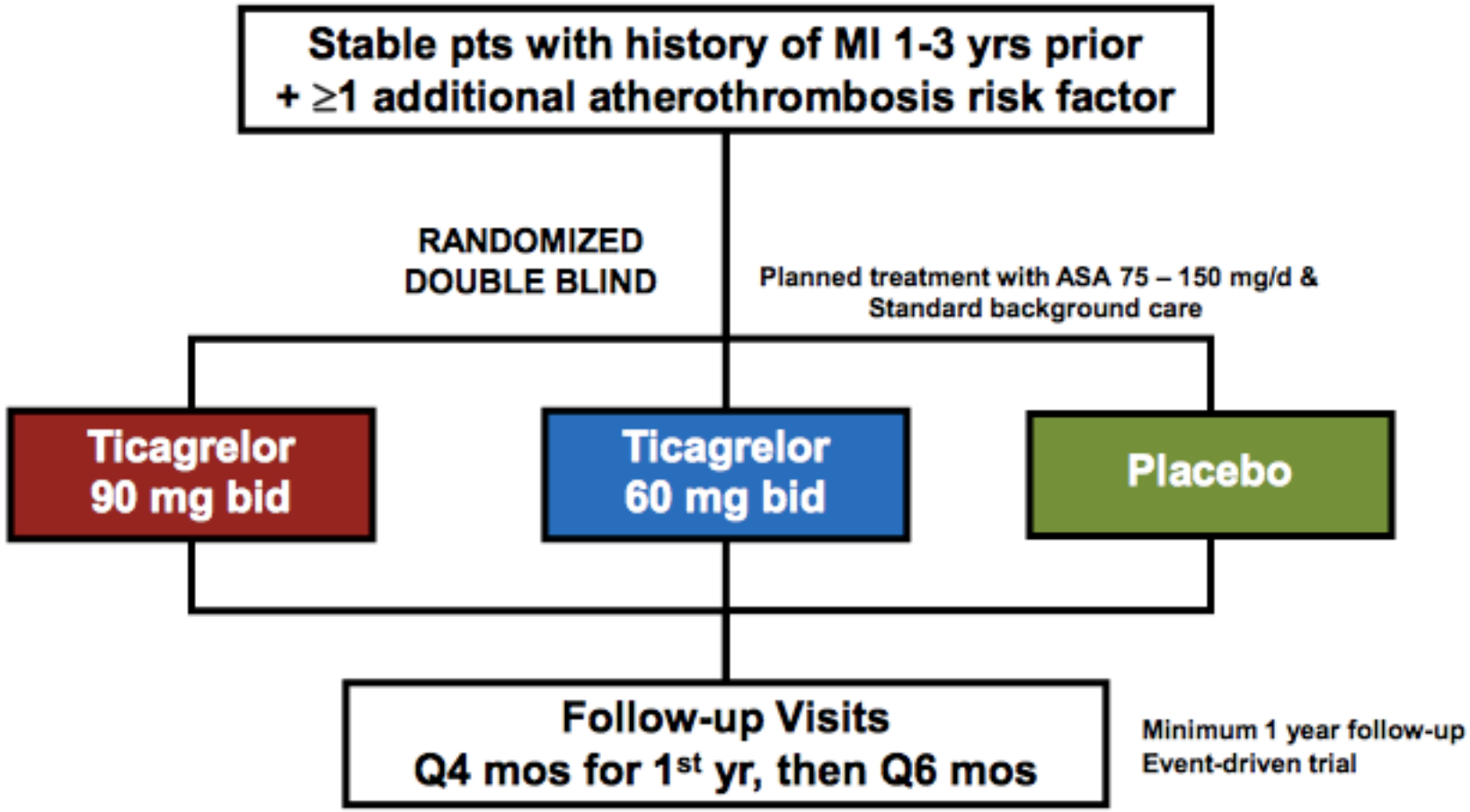
Donc débat en faveur longue durée DAPT mal engagé mais…

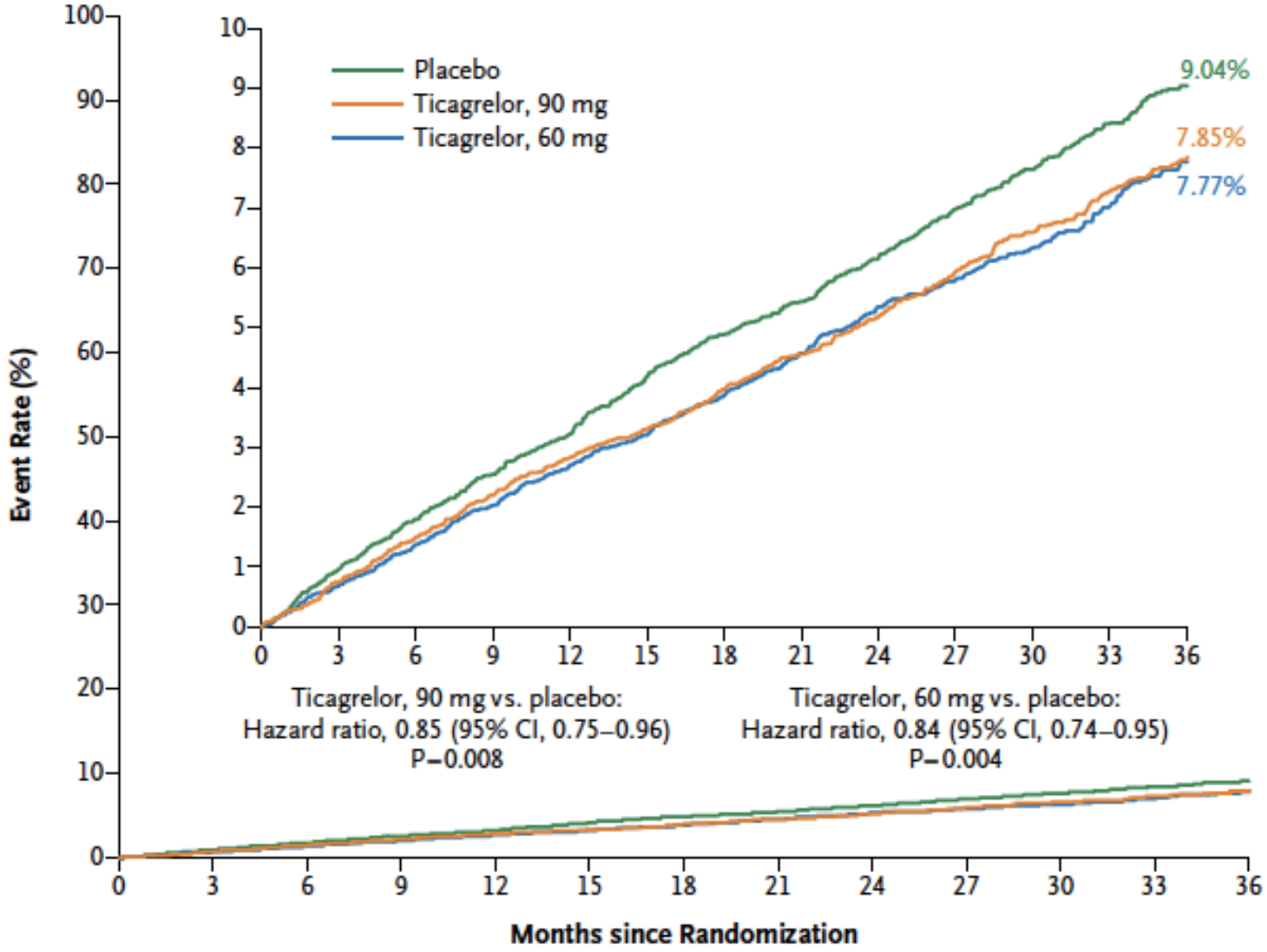
The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MAY 7, 2015 VOL. 372 NO. 19

Long-Term Use of Ticagrelor in Patients with Prior Myocardial Infarction

Marc P. Bonaca, M.D., M.P.H., Deepak L. Bhatt, M.D., M.P.H., Marc Cohen, M.D., Philippe Gabriel Steg, M.D., Robert F. Storey, M.D., Eva C. Jensen, M.D., Ph.D., Giulia Magnani, M.D., Sameer Bansilal, M.D., M. Polly Fish, B.A., Kyungah Im, Ph.D., Olof Bengtsson, Ph.Lic., Ton Oude Ophuis, M.D., Ph.D., Andrzej Budaj, M.D., Ph.D., Pierre Theroux, M.D., Mikhail Ruda, M.D., Christian Hamm, M.D., Shinya Goto, M.D., Jindrich Spinar, M.D., José Carlos Nicolau, M.D., Ph.D., Robert G. Kiss, M.D., Ph.D., Sabina A. Murphy, M.P.H., Stephen D. Wiviott, M.D., Peter Held, M.D., Ph.D., Eugene Braunwald, M.D., and Marc S. Sabatine, M.D., M.P.H., for the PEGASUS-TIMI 54 Steering Committee and Investigators*


Stable pts with history of MI 1-3 yrs prior
+ ≥1 additional atherothrombosis risk factor
RANDOMIZED
DOUBLE BLIND
Planned treatment with ASA 75 – 150 mg/d &
Standard background care
Ticagrelor
90 mg bid
Ticagrelor
60 mg bid
Placebo
Follow-up Visits
Q4 mos for 1st yr, then Q6 mos
Minimum 1 year follow-up
Event-driven trial


Placebo
Ticagrelor, 90 mg
Ticagrelor, 60 mg
9.04%
7.85%
7.77%
Event Rate (%)
Months since Randomization
Ticagrelor, 90 mg vs. placebo:
Hazard ratio, 0.85 (95% CI, 0.75–0.96)
P=0.008
Ticagrelor, 60 mg vs. placebo:
Hazard ratio, 0.84 (95% CI, 0.74–0.95)
P=0.004

SAIGNEMENTS

End Point	Ticagrelor, 90 mg (N=6988)	Ticagrelor, 60 mg (N=6958)	Placebo (N=6996)	Ticagrelor, 90 mg vs. Placebo		Ticagrelor, 60 mg vs. Placebo	
				Hazard Ratio (95% CI)	P Value	Hazard Ratio (95% CI)	P Value
	number (percent)						
Bleeding							
TIMI major bleeding	127 (2.60)	115 (2.30)	54 (1.06)	2.69 (1.96–3.70)	<0.001	2.32 (1.68–3.21)	<0.001
TIMI minor bleeding	66 (1.31)	55 (1.18)	18 (0.36)	4.15 (2.47–7.00)	<0.001	3.31 (1.94–5.63)	<0.001

Comment choisir ?
DAPT à la carte ….

Selon le sexe ?

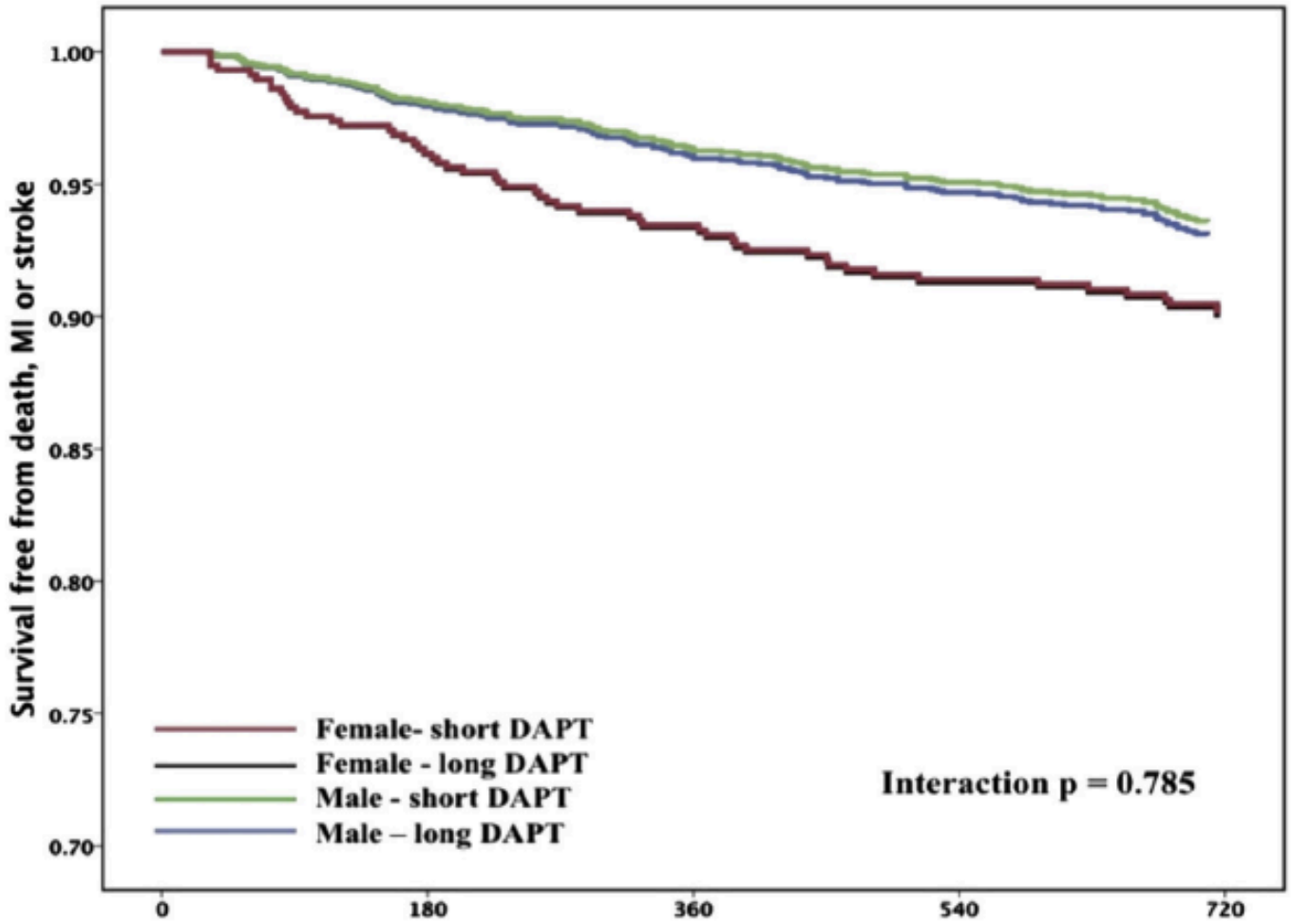
JACC: CARDIOVASCULAR INTERVENTIONS
VOL. 9, NO. 17, 2016

ISSN 1936-8798/$36.00
PUBLISHED BY ELSEVIER
http://dx.doi.org/10.1016/j.jcin.2016.05.046

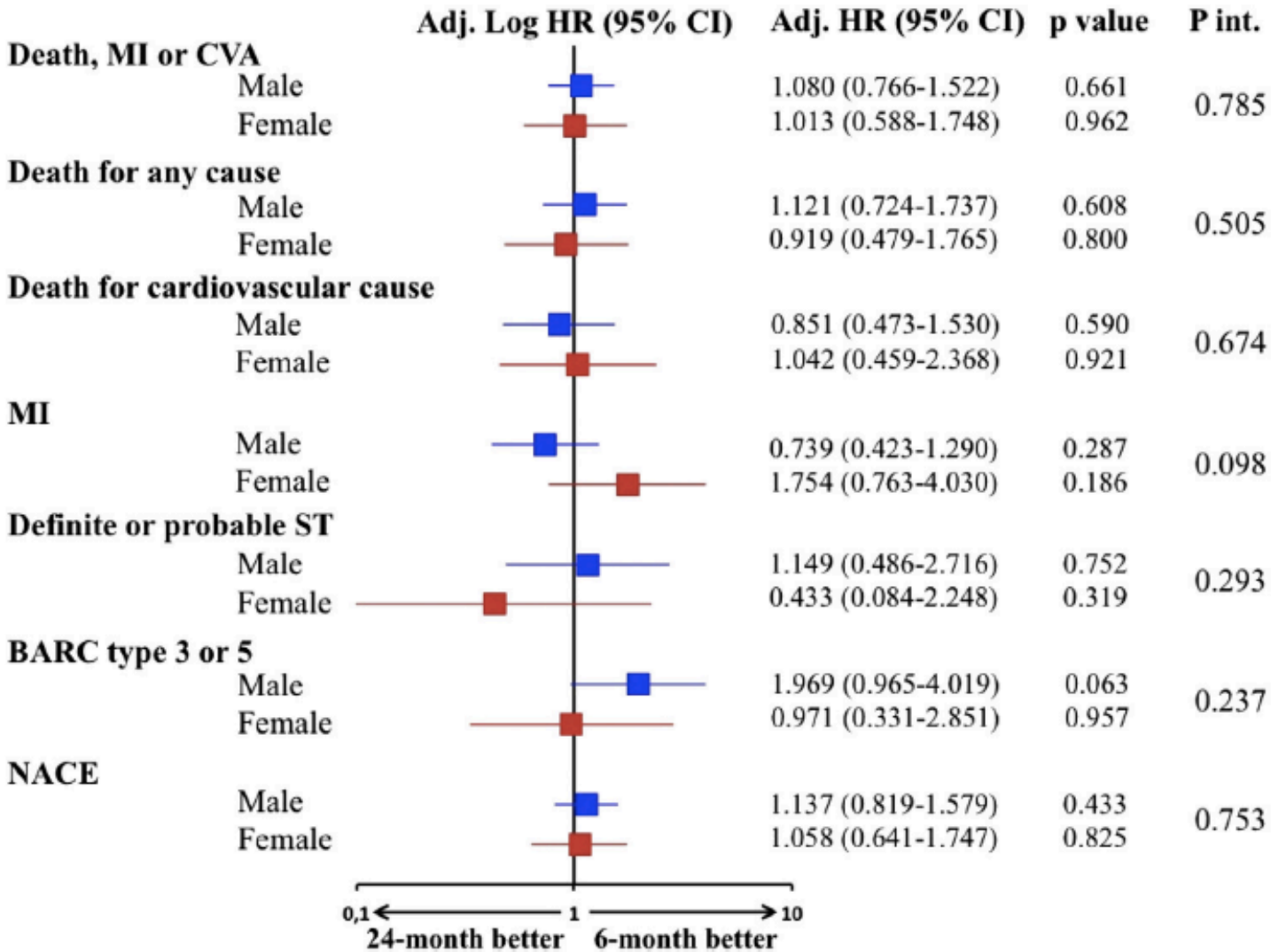
Impact of Sex on 2-Year Clinical Outcomes in Patients Treated With 6-Month or 24-Month Dual-Antiplatelet Therapy Duration

A Pre-Specified Analysis From the PRODIGY Trial

Giuseppe Gargiulo, MD,[a,b] Sara Ariotti, MD,[a,c] Andrea Santucci, MD,[a] Raffaele Piccolo, MD,[a] Andrea Baldo, MD,[a] Anna Franzone, MD,[a] Giulia Magnani, MD,[a] Marcello Marino, MD,[a] Giovanni Esposito, MD, PhD,[b] Stephan Windecker, MD,[a] Marco Valgimigli, MD, PhD[a,c]



Number at risk					
Female-short DAPT	236	223	220	213	206
Female-long DAPT	223	213	201	197	195
Male-short DAPT	747	724	699	689	675
Male-long DAPT	764	741	724	707	689

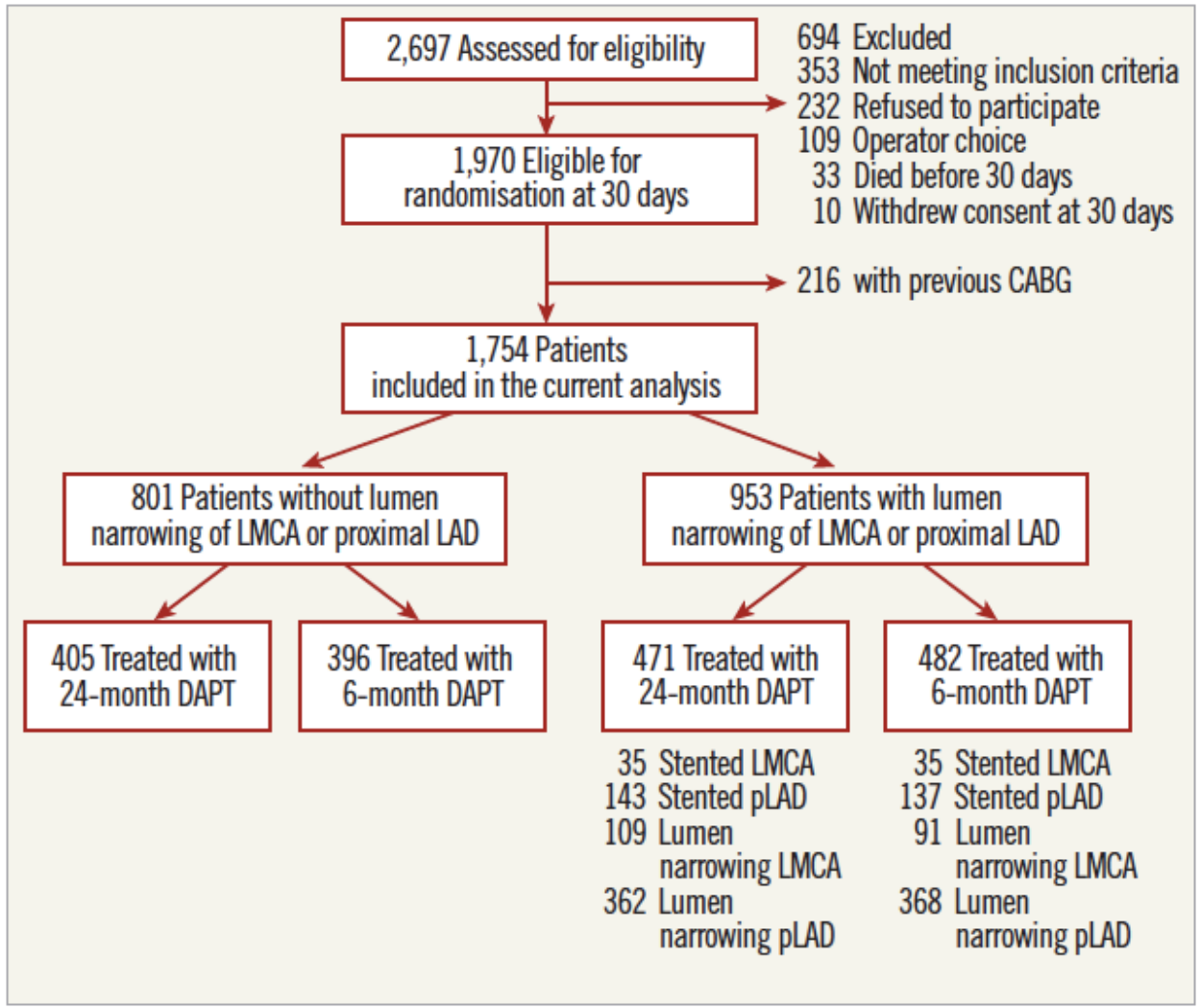

Adj. Log HR (95% CI)
Adj. HR (95% CI)
p value
P int.
Death, MI or CVA
Male
1.080 (0.766-1.522)
0.661
Female
1.013 (0.588-1.748)
0.962
0.785
Death for any cause
Male
1.121 (0.724-1.737)
0.608
Female
0.919 (0.479-1.765)
0.800
0.505
Death for cardiovascular cause
Male
0.851 (0.473-1.530)
0.590
Female
1.042 (0.459-2.368)
0.921
0.674
MI
Male
0.739 (0.423-1.290)
0.287
Female
1.754 (0.763-4.030)
0.186
0.098
Definite or probable ST
Male
1.149 (0.486-2.716)
0.752
Female
0.433 (0.084-2.248)
0.319
0.293
BARC type 3 or 5
Male
1.969 (0.965-4.019)
0.063
Female
0.971 (0.331-2.851)
0.957
0.237
NACE
Male
1.137 (0.819-1.579)
0.433
Female
1.058 (0.641-1.747)
0.825
0.753
0,1
1
10
24-month better
6-month better

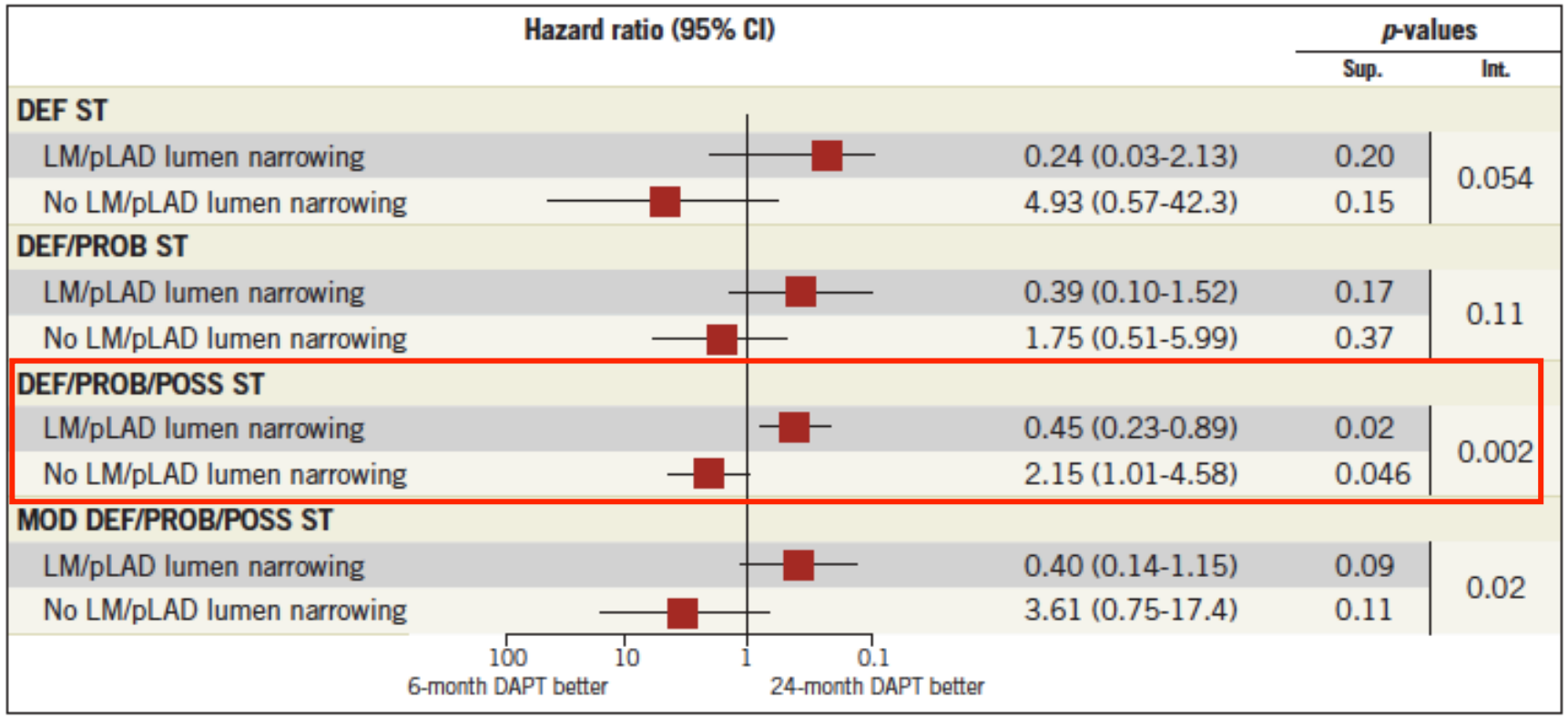
Si atteinte « pluritronculaire »?

CLINICAL RESEARCH
CORONARY INTERVENTIONS

Left main or proximal left anterior descending coronary artery disease location identifies high-risk patients deriving potentially greater benefit from prolonged dual antiplatelet therapy duration

Francesco Costa[1], MD; Marianna Adamo[1], MD; Sara Ariotti[1], MD; Giuseppe Ferrante[2], MD, PhD; Eliano Pio Navarese[3], MD, PhD; Sergio Leonardi[4], MD; Hector Garcia-Garcia[5], MD, PhD; Pascal Vranckx[6], MD, PhD; Marco Valgimigli[1]*, MD, PhD


2,697 Assessed for eligibility
694 Excluded
353 Not meeting inclusion criteria
232 Refused to participate
109 Operator choice
33 Died before 30 days
10 Withdrew consent at 30 days
1,970 Eligible for randomisation at 30 days
216 with previous CABG
1,754 Patients included in the current analysis
801 Patients without lumen narrowing of LMCA or proximal LAD
953 Patients with lumen narrowing of LMCA or proximal LAD
405 Treated with 24-month DAPT
396 Treated with 6-month DAPT
471 Treated with 24-month DAPT
482 Treated with 6-month DAPT
35 Stented LMCA
143 Stented pLAD
109 Lumen narrowing LMCA
362 Lumen narrowing pLAD
35 Stented LMCA
137 Stented pLAD
91 Lumen narrowing LMCA
368 Lumen narrowing pLAD

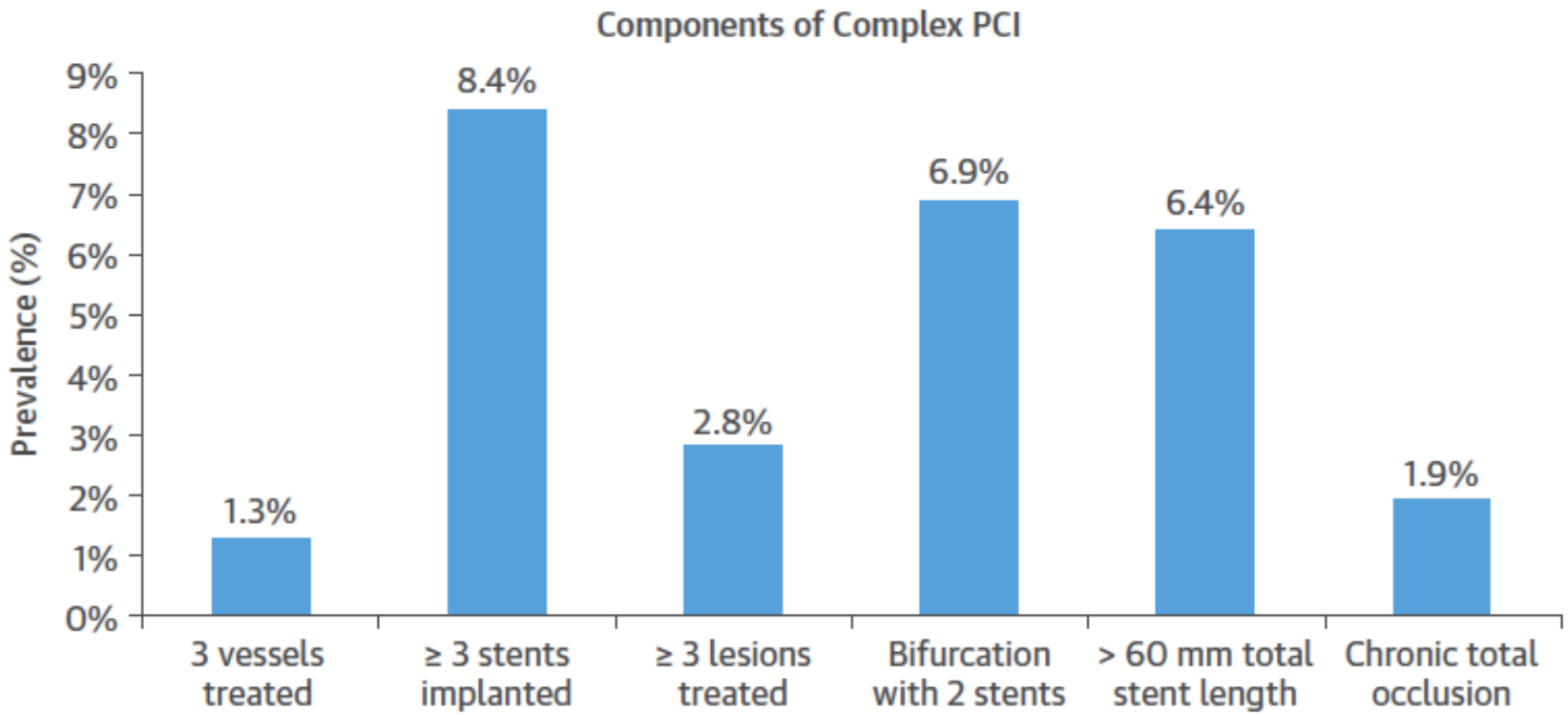

Hazard ratio (95% CI)
p-values
Sup.
Int.
DEF ST
LM/pLAD lumen narrowing
0.24 (0.03-2.13)
0.20
0.054
No LM/pLAD lumen narrowing
4.93 (0.57-42.3)
0.15
DEF/PROB ST
LM/pLAD lumen narrowing
0.39 (0.10-1.52)
0.17
0.11
No LM/pLAD lumen narrowing
1.75 (0.51-5.99)
0.37
DEF/PROB/POSS ST
LM/pLAD lumen narrowing
0.45 (0.23-0.89)
0.02
0.002
No LM/pLAD lumen narrowing
2.15 (1.01-4.58)
0.046
MOD DEF/PROB/POSS ST
LM/pLAD lumen narrowing
0.40 (0.14-1.15)
0.09
0.02
No LM/pLAD lumen narrowing
3.61 (0.75-17.4)
0.11
100
10
1
0.1
6-month DAPT better
24-month DAPT better

JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. 68, NO. 17, 2016

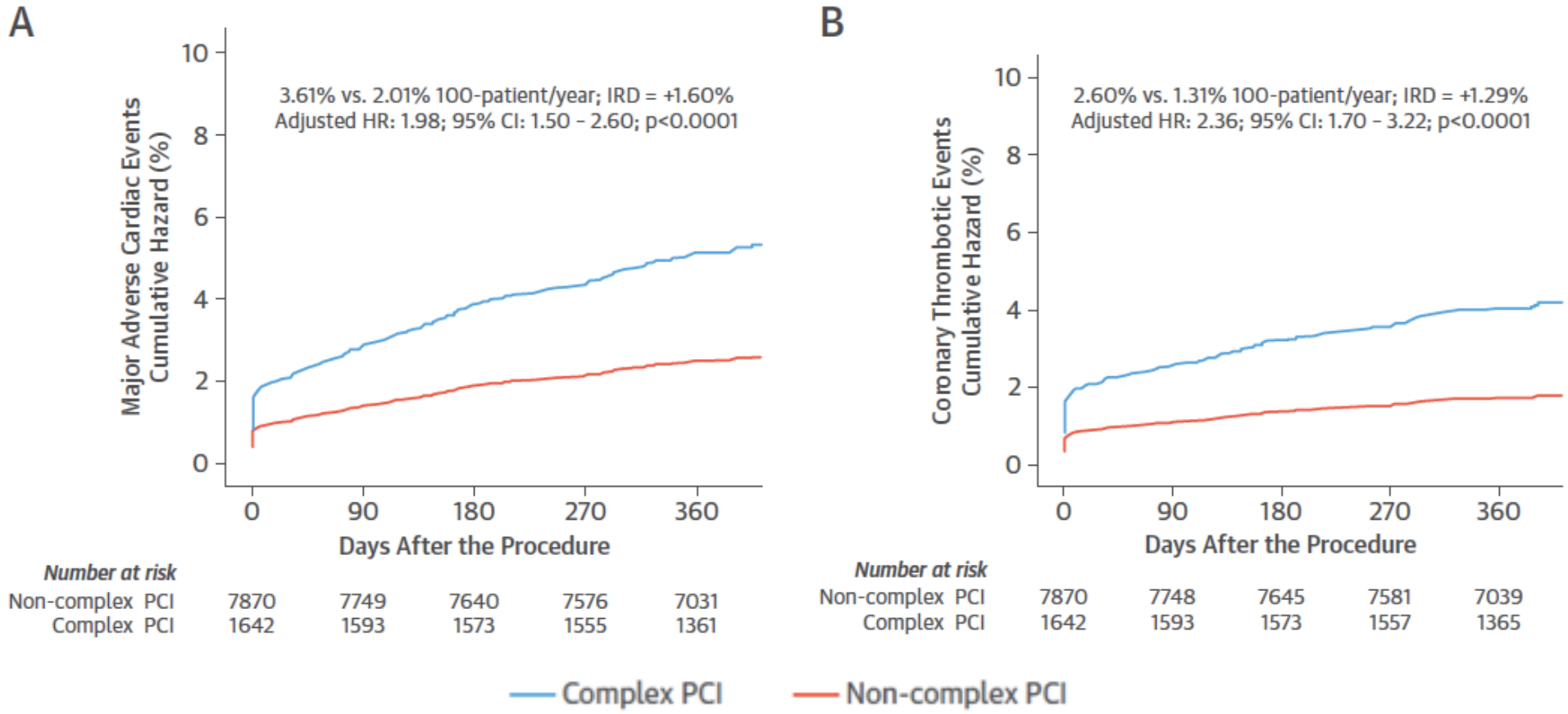
ISSN 0735-1097/$36.00
PUBLISHED BY ELSEVIER
http://dx.doi.org/10.1016/j.jacc.2016.07.760

Efficacy and Safety of Dual Antiplatelet Therapy After Complex PCI

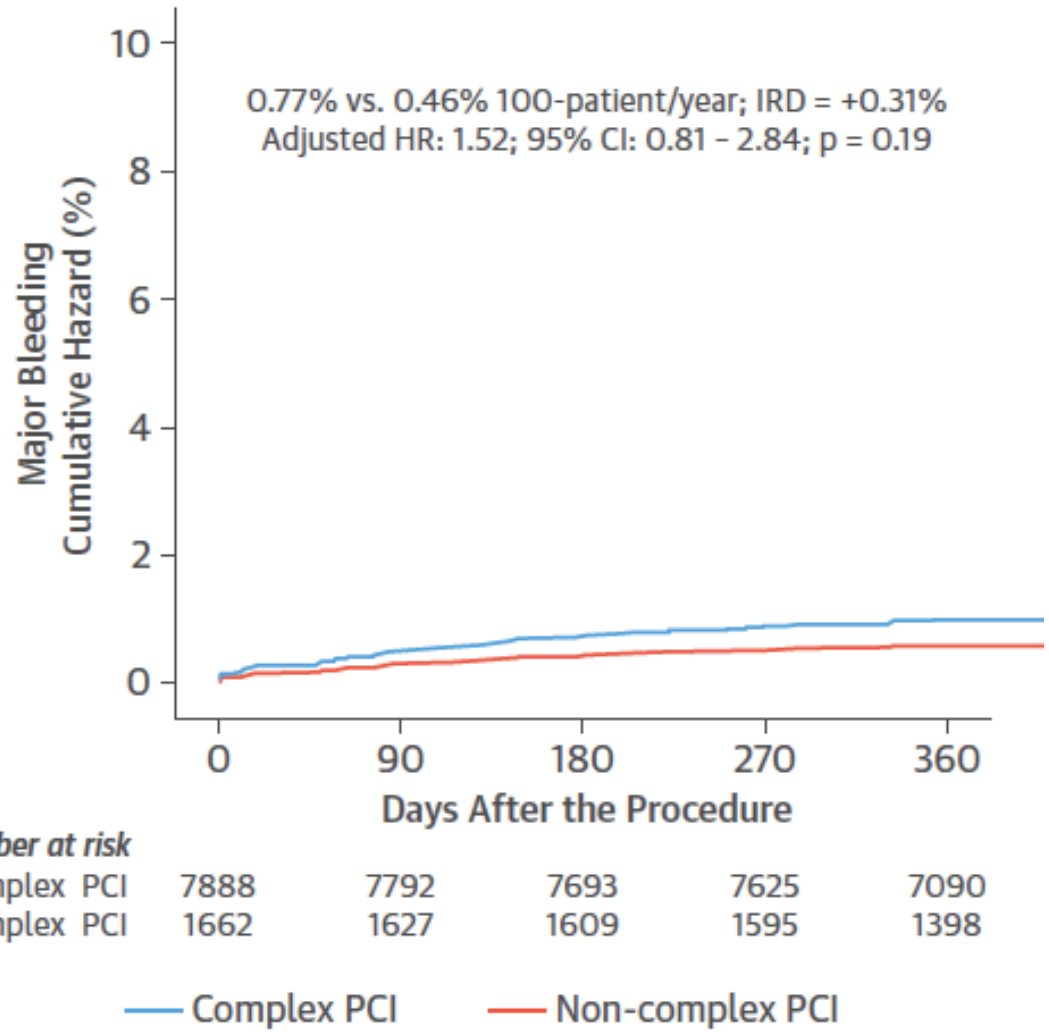
Gennaro Giustino, MD,[a,b,c] Alaide Chieffo, MD,[c] Tullio Palmerini, MD,[d] Marco Valgimigli, MD, PhD,[e] Fausto Feres, MD,[f] Alexandre Abizaid, MD,[f] Ricardo A. Costa, MD,[f] Myeong-Ki Hong, MD, PhD,[g] Byeong-Keuk Kim, MD, PhD,[g] Yangsoo Jang, MD, PhD,[g] Hyo-Soo Kim, MD, PhD,[h] Kyung Woo Park, MD,[h] Martine Gilard, MD,[i] Marie-Claude Morice, MD,[j] Fadi Sawaya, MD,[j] Gennaro Sardella, MD,[k] Philippe Genereux, MD,[b,l] Bjorn Redfors, MD, PhD,[b] Martin B. Leon, MD,[c,l] Deepak L. Bhatt, MD, MPH,[m] Gregg W. Stone, MD,[b,l] Antonio Colombo, MD[c]


Components of Complex PCI
Prevalence (%)
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
1.3%
8.4%
2.8%
6.9%
6.4%
1.9%
3 vessels treated
≥ 3 stents implanted
≥ 3 lesions treated
Bifurcation with 2 stents
> 60 mm total stent length
Chronic total occlusion

Plus d'événements Indépendamment de la durée DAPT si ATC complexe.

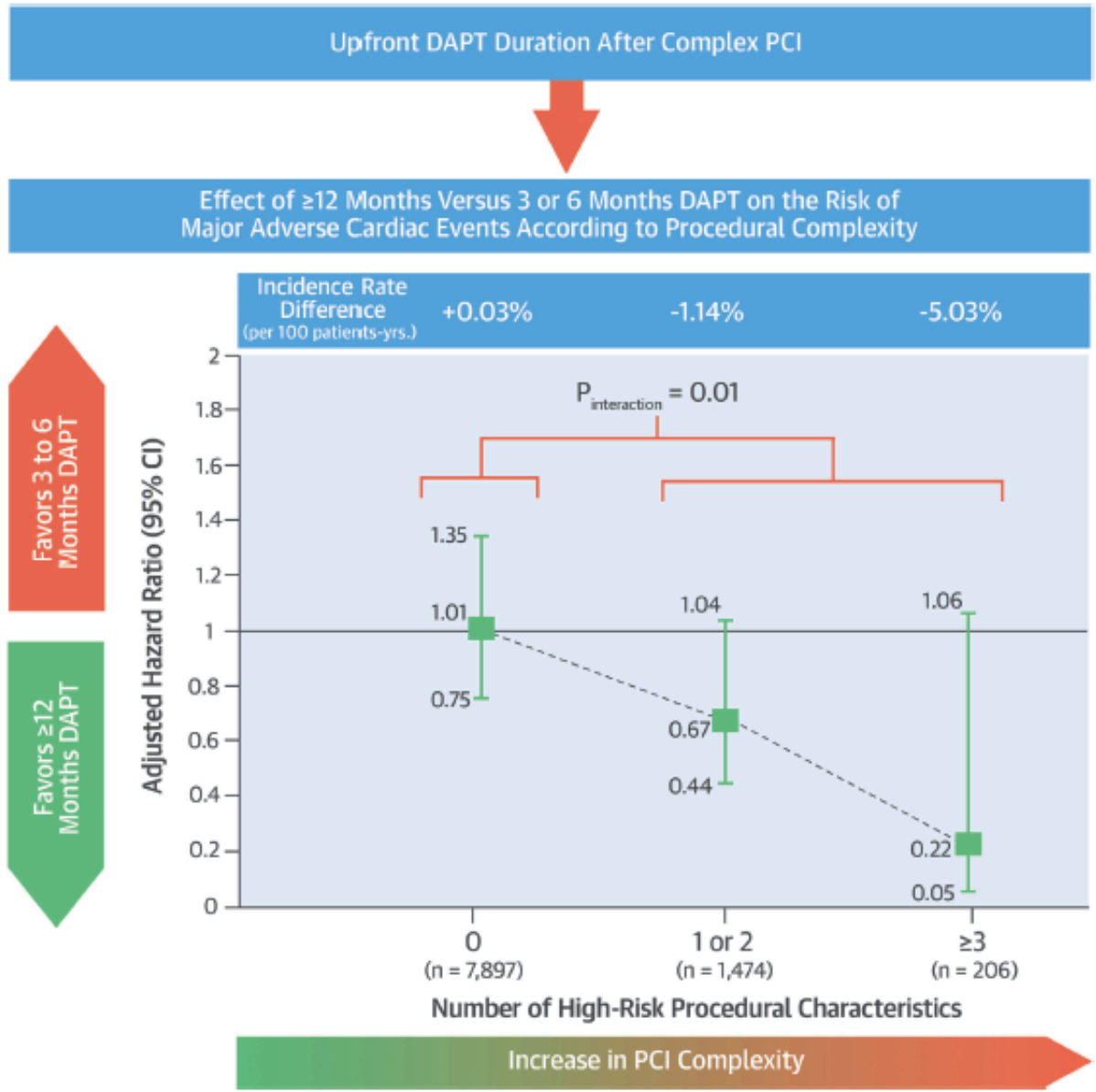


C



Number at risk

Non-complex PCI	7888	7792	7693	7625	7090
Complex PCI	1662	1627	1609	1595	1398


Upfront DAPT Duration After Complex PCI
Effect of ≥12 Months Versus 3 or 6 Months DAPT on the Risk of Major Adverse Cardiac Events According to Procedural Complexity
Incidence Rate Difference (per 100 patients-yrs.)
+0.03%
-1.14%
-5.03%
Favors 3 to 6 Months DAPT
Favors ≥12 Months DAPT
Adjusted Hazard Ratio (95% CI)
P interaction = 0.01
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
1.35
1.01
0.75
1.04
0.67
0.44
1.06
0.22
0.05
0
(n = 7,897)
1 or 2
(n = 1,474)
≥3
(n = 206)
Number of High-Risk Procedural Characteristics
Increase in PCI Complexity

Selon les tests de réactivité plaquettaires ?

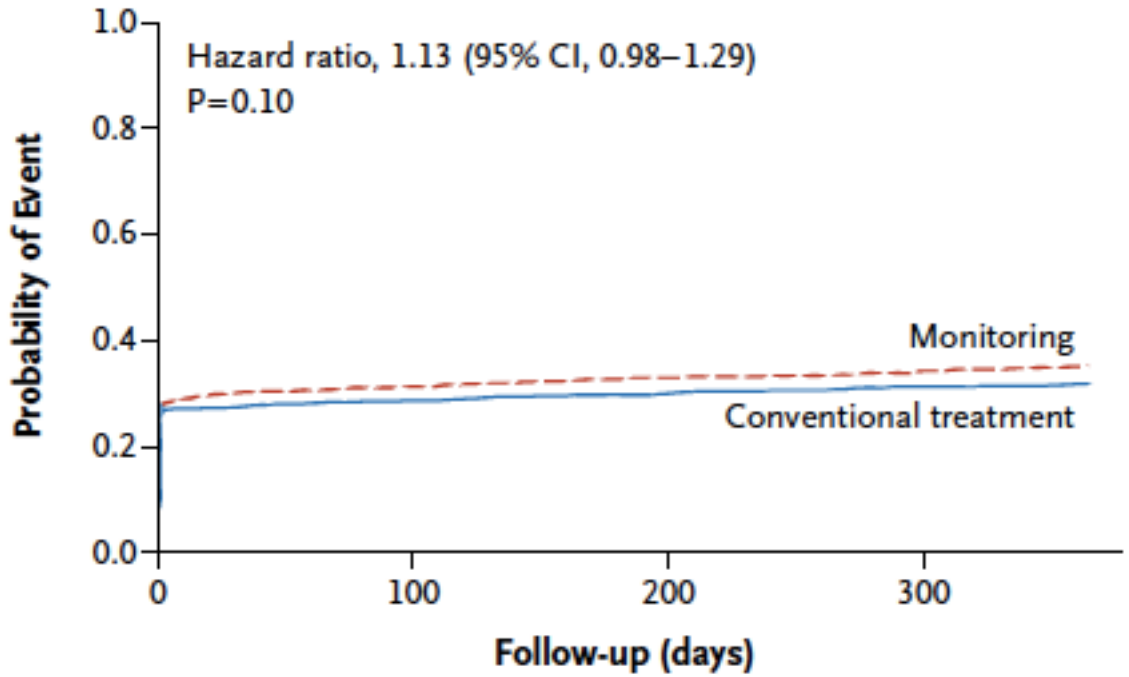
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Bedside Monitoring to Adjust Antiplatelet Therapy for Coronary Stenting

Jean-Philippe Collet, M.D., Ph.D., Thomas Cuisset, M.D., Ph.D., Grégoire Rangé, M.D., Guillaume Cayla, M.D., Ph.D., Simon Elhadad, M.D., Christophe Pouillot, M.D., Patrick Henry, M.D., Ph.D., Pascal Motreff, M.D., Ph.D., Didier Carrié, M.D., Ziad Boueri, M.D., Ph.D., Loic Belle, M.D., Eric Van Belle, M.D., Ph.D., Hélène Rousseau, Ph.D., Pierre Aubry, M.D., Jacques Monségu, M.D., Pierre Sabouret, M.D., Stephen A. O'Connor, M.B., B.Ch., Jérémie Abtan, M.D., Mathieu Kerneis, M.D., Christophe Saint-Etienne, M.D., Olivier Barthélémy, M.D., Farzin Beygui, M.D., Ph.D., Johanne Silvain, M.D., Ph.D., Eric Vicaut M.D., Ph.D., and Gilles Montalescot, M.D., Ph.D., for the ARCTIC Investigators*

A Primary End Point



No. at Risk				
Conventional treatment	1227	835	801	767
Monitoring	1213	790	762	730

SCORES ?

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 4, 2014 VOL. 371 NO. 23

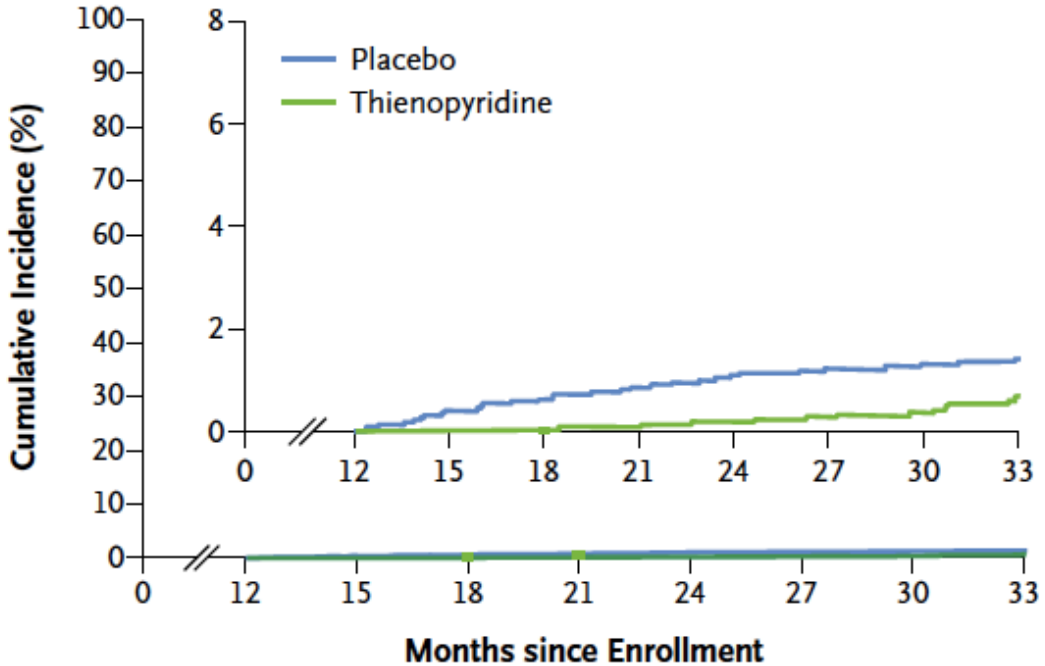
Twelve or 30 Months of Dual Antiplatelet Therapy after Drug-Eluting Stents

Laura Mauri, M.D., Dean J. Kereiakes, M.D., Robert W. Yeh, M.D., Priscilla Driscoll-Shempp, M.B.A., Donald E. Cutlip, M.D., P. Gabriel Steg, M.D., Sharon-Lise T. Normand, Ph.D., Eugene Braunwald, M.D., Stephen D. Wiviott, M.D., David J. Cohen, M.D., David R. Holmes, Jr., M.D., Mitchell W. Krucoff, M.D., James Hermiller, M.D., Harold L. Dauerman, M.D., Daniel I. Simon, M.D., David E. Kandzari, M.D., Kirk N. Garratt, M.D., David P. Lee, M.D., Thomas K. Pow, M.D., Peter Ver Lee, M.D., Michael J. Rinaldi, M.D., and Joseph M. Massaro, Ph.D., for the DAPT Study Investigators*

Stent Thrombosis

12–30 mo Thienopyridine vs. placebo, 0.4% vs. 1.4%; hazard ratio, 0.29; P<0.001

12–33 mo Thienopyridine vs. placebo, 0.7% vs. 1.4%; hazard ratio, 0.45; P<0.001



No. at Risk

Thienopyridine	5020	4934	4870	4828	4765	4686	4642	3110
Placebo	4941	4845	4775	4721	4651	4603	4556	3105

Bleeding Complications	Continued Thienopyridine (N=4710)	Placebo (N=4649)	Difference	Two-Sided P Value for Difference
	no. of patients (%)		*percentage points (95% CI)*	
GUSTO severe or moderate†	119 (2.5)	73 (1.6)	1.0 (0.4 to 1.5)	0.001
Severe	38 (0.8)	26 (0.6)	0.2 (–0.1 to 0.6)	0.15
Moderate	81 (1.7)	48 (1.0)	0.7 (0.2 to 1.2)	0.004
BARC type 2, 3, or 5	263 (5.6)	137 (2.9)	2.6 (1.8 to 3.5)	<0.001
Type 2	145 (3.1)	72 (1.5)	1.5 (0.9 to 2.1)	<0.001
Type 3	122 (2.6)	68 (1.5)	1.1 (0.6 to 1.7)	<0.001
Type 5	7 (0.1)	4 (0.1)	0.1 (–0.1 to 0.2)	0.38

JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. 67, NO. 21, 2016

ISSN 0735-1097/$36.00
PUBLISHED BY ELSEVIER
http://dx.doi.org/10.1016/j.jacc.2016.03.485

DAPT Score Utility for Risk Prediction in Patients With or Without Previous Myocardial Infarction

Dean J. Kereiakes, MD,[a] Robert W. Yeh, MD,[b,c,d] Joseph M. Massaro, PhD,[c,e] Donald E. Cutlip, MD,[b,c,f] P. Gabriel Steg, MD,[g,h,i,j] Stephen D. Wiviott, MD,[b,k] Laura Mauri, MD,[b,c,k] on behalf of the DAPT Study Investigators

DAPT score[15]

After 12 months of uneventful DAPT

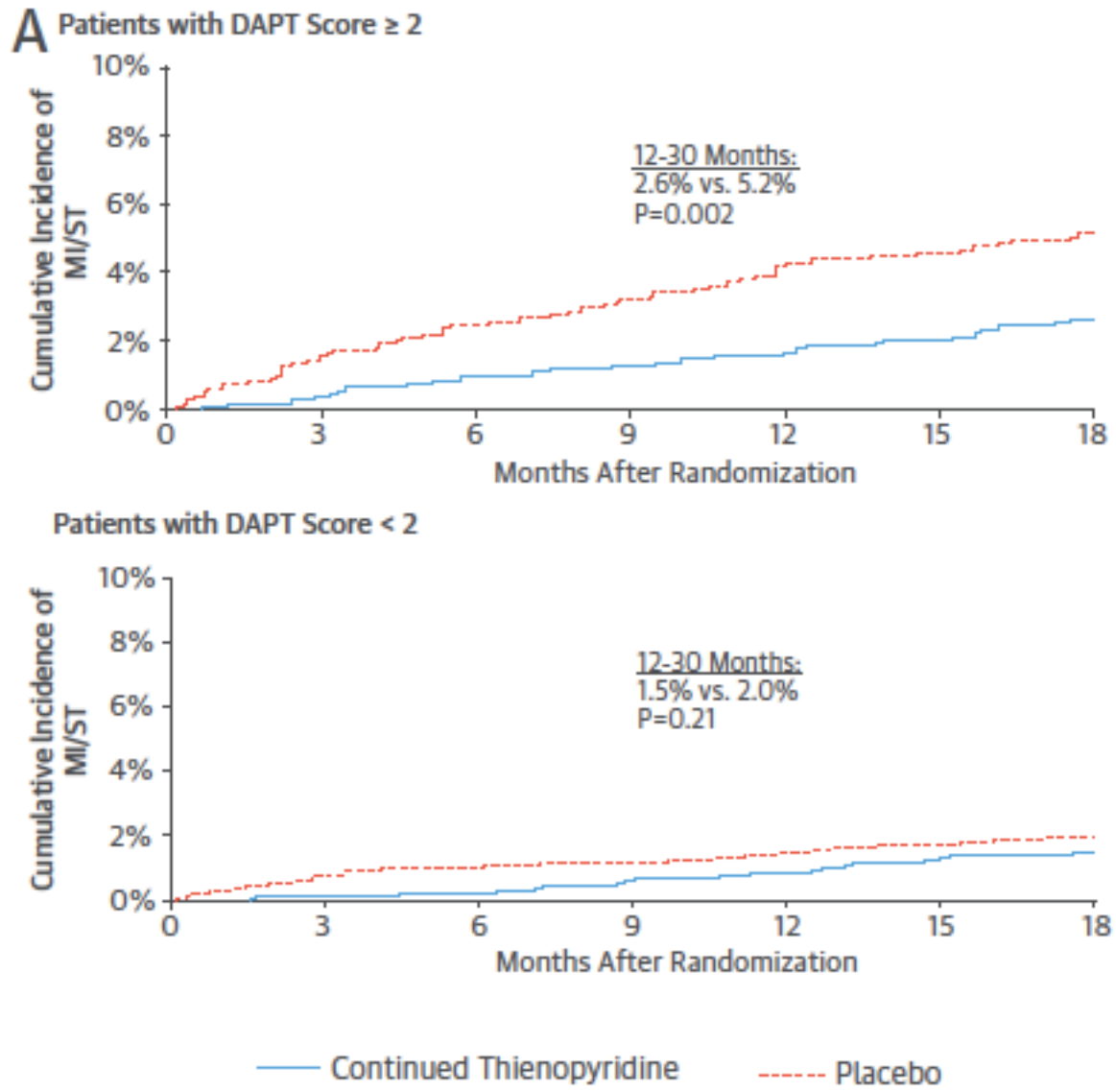
Standard DAPT (12 months)
vs.
Long DAPT (30 months)

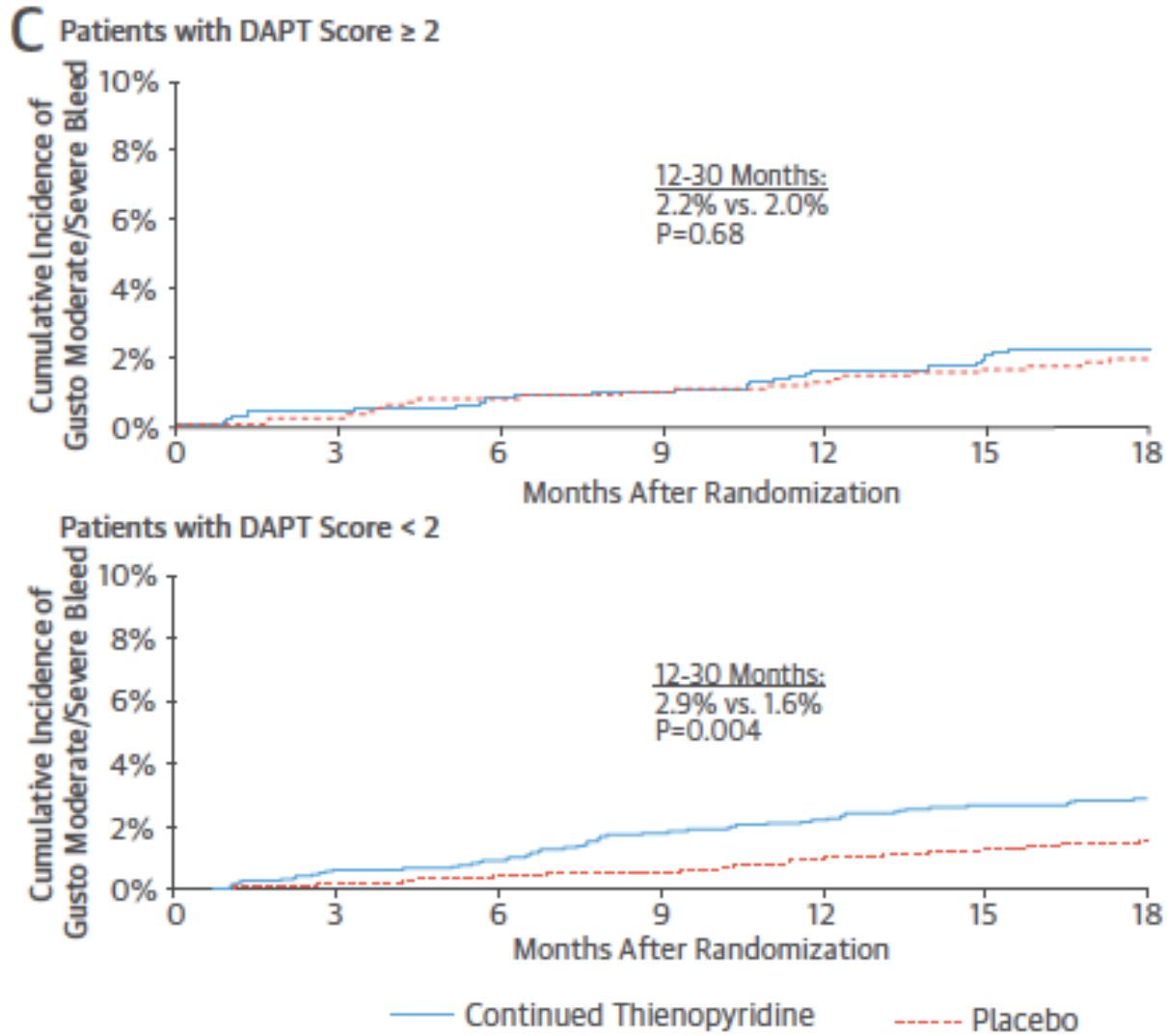
Age	
≥75	–2 pt
65 to <75	–1 pt
<65	0 pt
Cigarette smoking	+1 pt
Diabetes mellitus	+1 pt
MI at presentation	+1 pt
Prior PCI or prior MI	+1 pt
Paclitaxel-eluting stent	+1 pt
Stent diameter <3 mm	+1 pt
CHF or LVEF <30%	+2 pt
Vein graft stent	+2 pt

–2 to 10 points

Score ≥2 → Long DAPT
Score <2 → Standard DAPT

www.daptstudy.org


A
Patients with DAPT Score ≥ 2
Cumulative Incidence of MI/ST
10%
8%
6%
4%
2%
0%
12-30 Months:
2.6% vs. 5.2%
P=0.002
0
3
6
9
12
15
18
Months After Randomization
Patients with DAPT Score < 2
Cumulative Incidence of MI/ST
10%
8%
6%
4%
2%
0%
12-30 Months:
1.5% vs. 2.0%
P=0.21
0
3
6
9
12
15
18
Months After Randomization
Continued Thienopyridine
Placebo


C
Patients with DAPT Score ≥ 2
Cumulative Incidence of Gusto Moderate/Severe Bleed
10%
8%
6%
4%
2%
0%
12-30 Months:
2.2% vs. 2.0%
P=0.68
0
3
6
9
12
15
18
Months After Randomization
Patients with DAPT Score < 2
Cumulative Incidence of Gusto Moderate/Severe Bleed
10%
8%
6%
4%
2%
0%
12-30 Months:
2.9% vs. 1.6%
P=0.004
0
3
6
9
12
15
18
Months After Randomization
Continued Thienopyridine
Placebo

La génétique ?

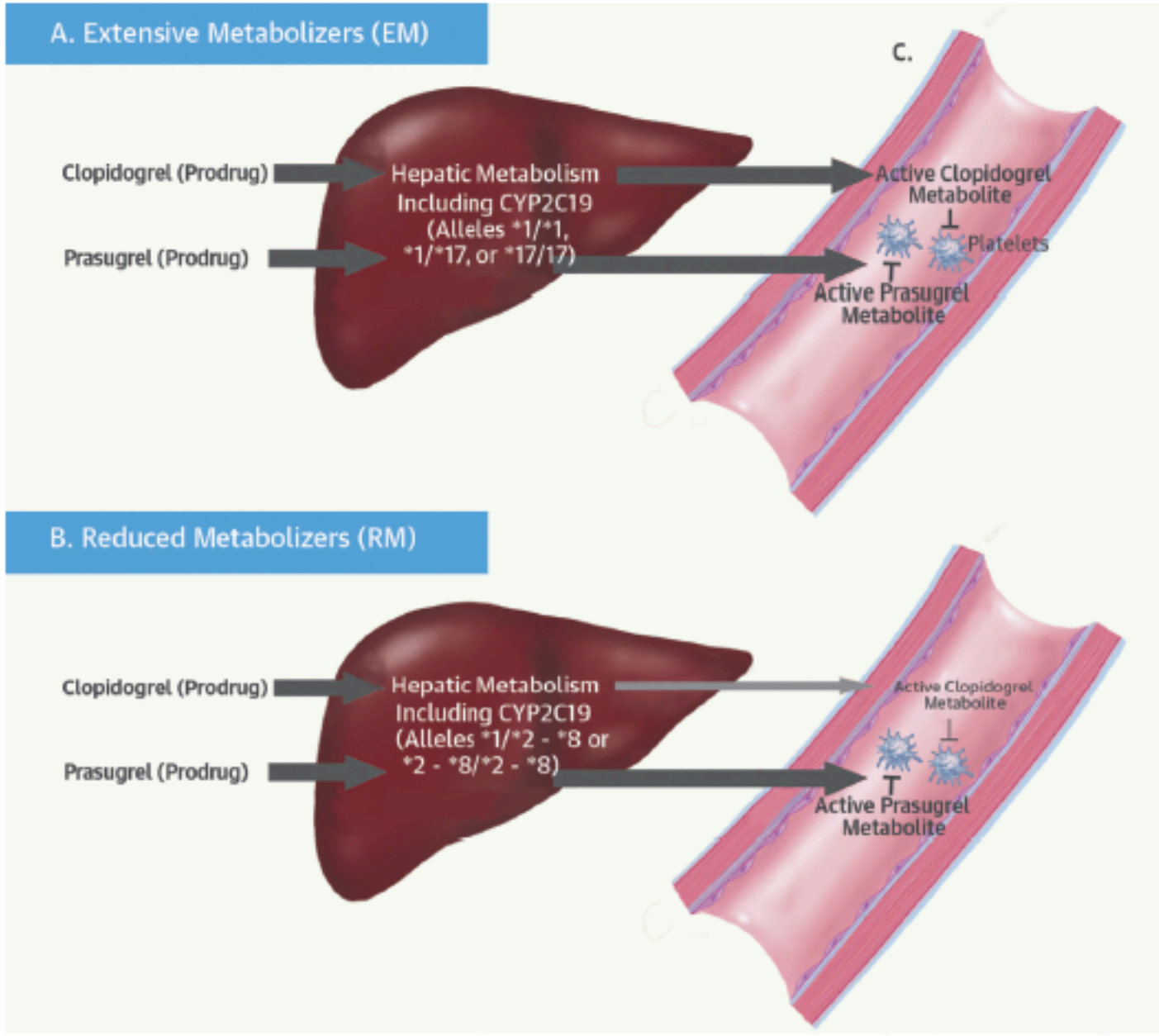
JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
VOL. 67, NO. 8, 2016

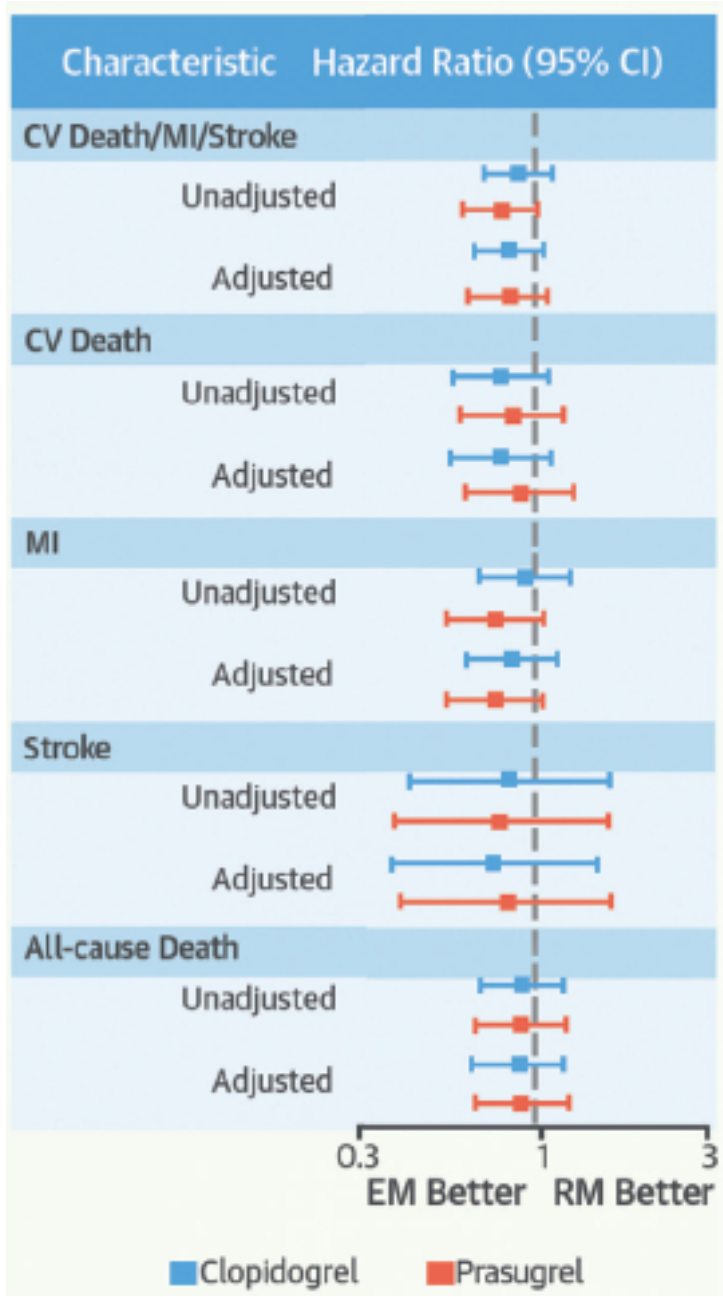
ISSN 0735-1097/$36.00
PUBLISHED BY ELSEVIER
http://dx.doi.org/10.1016/j.jacc.2015.12.036

Impact of CYP2C19 Metabolizer Status on Patients With ACS Treated With Prasugrel Versus Clopidogrel

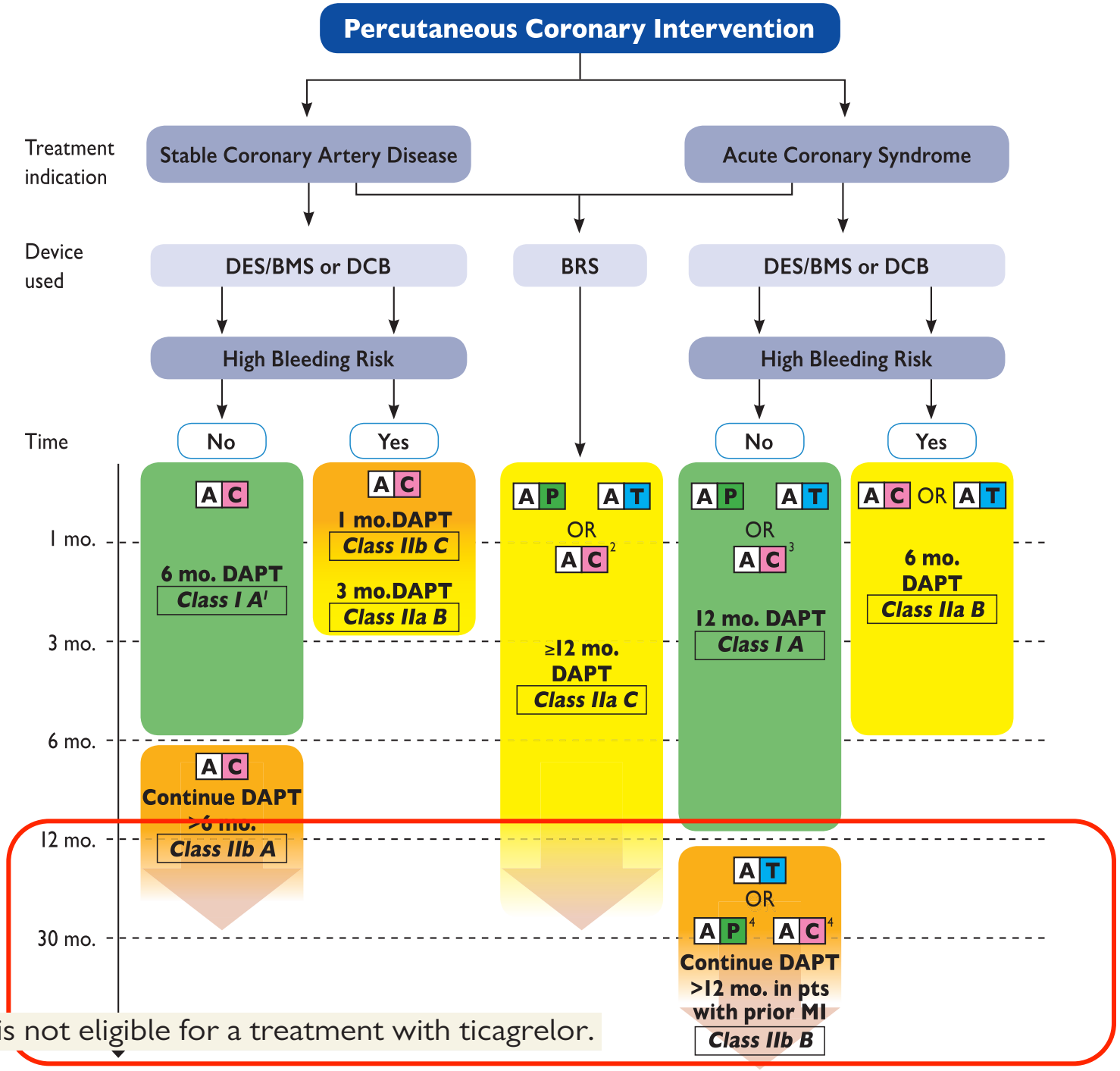
Jacob A. Doll, MD,[a] Megan L. Neely, PhD,[b] Matthew T. Roe, MD, MHS,[a,b] Paul W. Armstrong, MD,[c] Harvey D. White, MB, ChB, DSc,[d] Dorairaj Prabhakaran, MD, DM, MSc,[e] Kenneth J. Winters, MD,[f] Suman Duvvuru, PhD,[f] Scott S. Sundseth, PhD,[g] Joseph A. Jakubowski, PhD,[f] Paul A. Gurbel, MD,[h] Deepak L. Bhatt, MD, MPH,[i] E. Magnus Ohman, MD,[a,b] Keith A.A. Fox, MB, ChB,[j] for the TRILOGY ACS Investigators

SCA traités médicalement

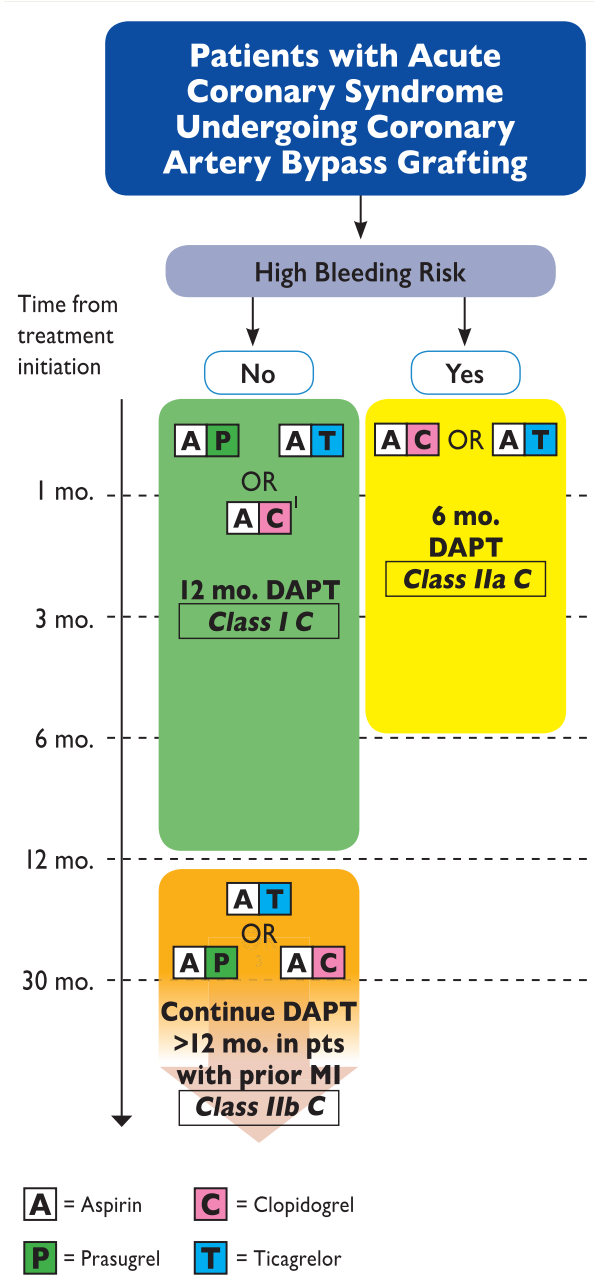

A. Extensive Metabolizers (EM)
C.
Clopidogrel (Prodrug)
Prasugrel (Prodrug)
Hepatic Metabolism
Including CYP2C19
(Alleles *1/*1,
*1/*17, or *17/17)
Active Clopidogrel
Metabolite
Platelets
Active Prasugrel
Metabolite
B. Reduced Metabolizers (RM)
Clopidogrel (Prodrug)
Prasugrel (Prodrug)
Hepatic Metabolism
Including CYP2C19
(Alleles *1/*2 - *8 or
*2 - *8/*2 - *8)
Active Clopidogrel
Metabolite
Active Prasugrel
Metabolite


Characteristic
Hazard Ratio (95% CI)
CV Death/MI/Stroke
Unadjusted
Adjusted
CV Death
Unadjusted
Adjusted
MI
Unadjusted
Adjusted
Stroke
Unadjusted
Adjusted
All-cause Death
Unadjusted
Adjusted
0.3
1
3
EM Better
RM Better
Clopidogrel
Prasugrel

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



[4]: If patient is not eligible for a treatment with ticagrelor.

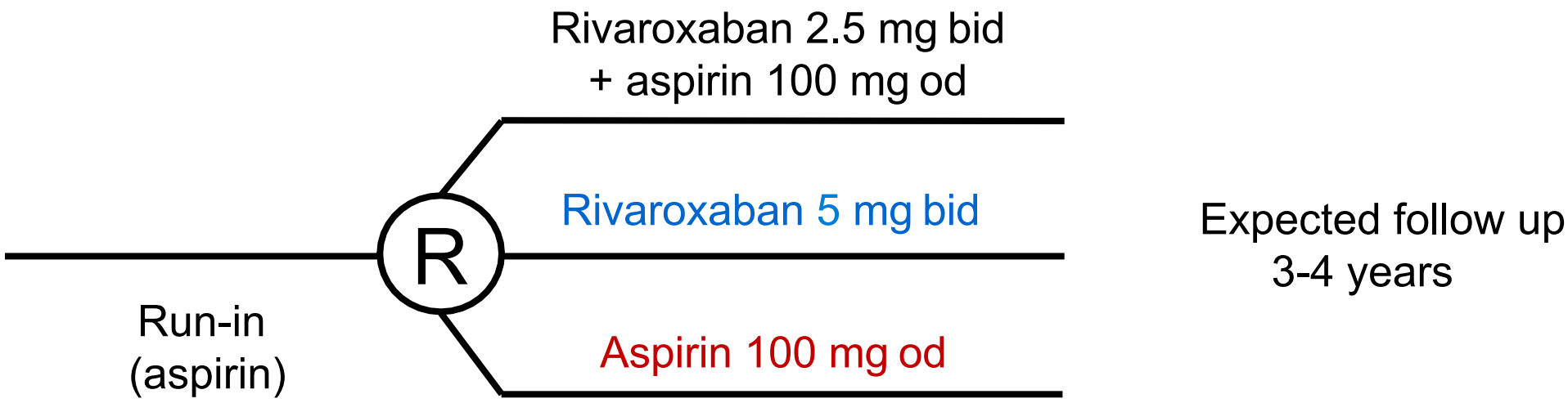

Patients with Acute Coronary Syndrome Undergoing Coronary Artery Bypass Grafting
High Bleeding Risk
Time from treatment initiation
No
Yes
1 mo.
3 mo.
6 mo.
12 mo.
30 mo.
A P
A T
OR
A C
12 mo. DAPT
Class I C
A C OR A T
6 mo. DAPT
Class IIa C
A T
OR
A P
A C
Continue DAPT >12 mo. in pts with prior MI
Class IIb C
A = Aspirin
C = Clopidogrel
P = Prasugrel
T = Ticagrelor

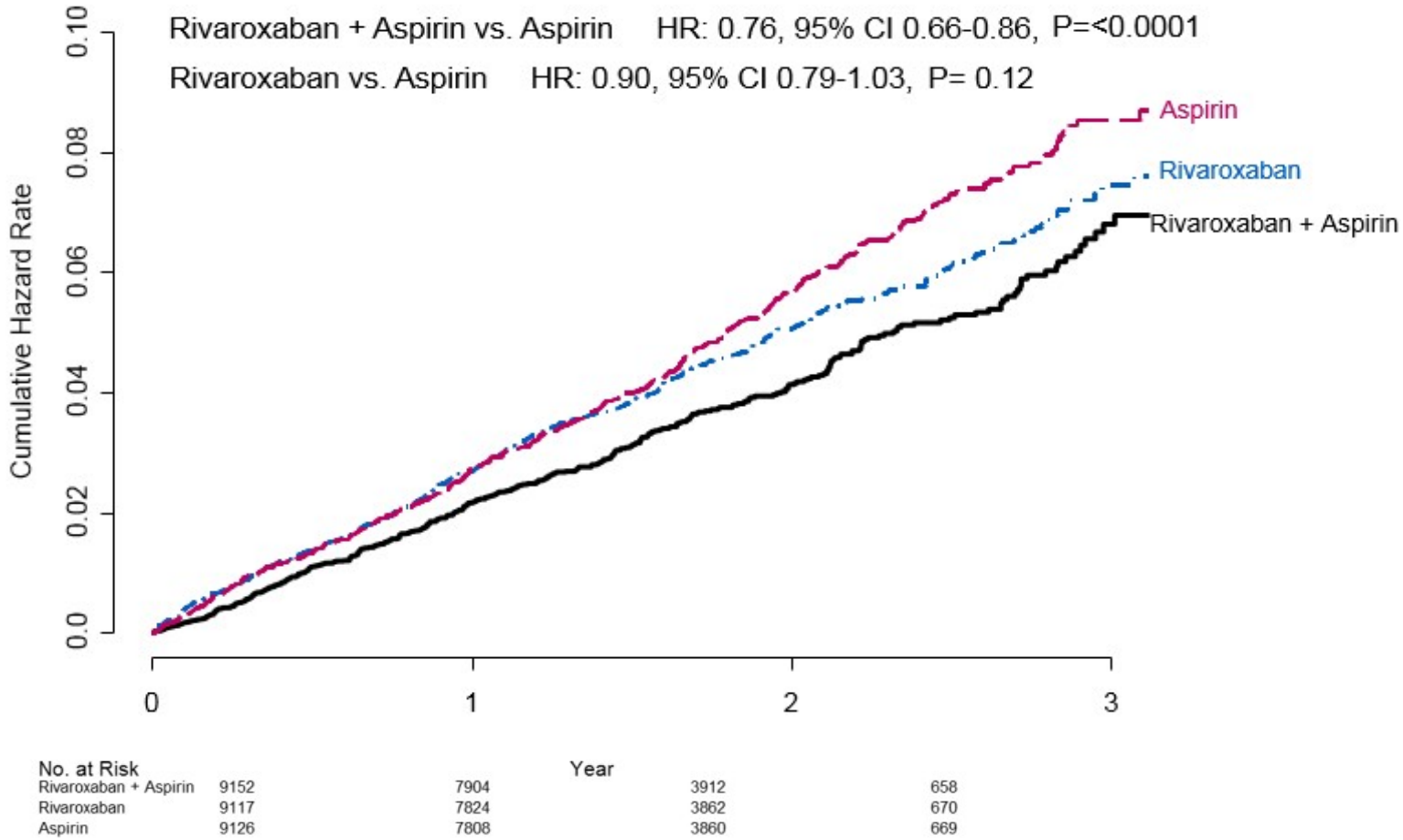
Rivaroxaban with or without aspirin in patients with stable coronary artery disease: an international, randomised, double-blind, placebo-controlled trial

*Stuart J Connolly, John W Eikelboom, Jackie Bosch, Gilles Dagenais, Leanne Dyal, Fernando Lanas, Kaj Metsarinne, Martin O'Donnell, Anthony L Dans, Jong-Won Ha, Alexandr N Parkhomenko, Alvaro A Avezum, Eva Lonn, Liu Lisheng, Christian Torp-Pedersen, Petr Widimsky, Aldo P Maggioni, Camilo Felix, Katalin Keltai, Masatsugu Hori, Khalid Yusoff, Tomasz J Guzik, Deepak L Bhatt, Kelley R H Branch, Nancy Cook Bruns, Scott D Berkowitz, Sonia S Anand, John D Varigos, Keith A A Fox, Salim Yusuf, on behalf of the COMPASS investigators**

COMPASS design

Stable CAD or PAD
2,200 with a primary outcome event




Rivaroxaban + Aspirin vs. Aspirin HR: 0.76, 95% CI 0.66-0.86, P=<0.0001
Rivaroxaban vs. Aspirin HR: 0.90, 95% CI 0.79-1.03, P= 0.12
Aspirin
Rivaroxaban
Rivaroxaban + Aspirin
Cumulative Hazard Rate
0.0
0.02
0.04
0.06
0.08
0.10
0
1
2
3
Year
No. at Risk
Rivaroxaban + Aspirin 9152 7904 3912 658
Rivaroxaban 9117 7824 3862 670
Aspirin 9126 7808 3860 669

Major bleeding

Outcome	R + A N=9,152	R N=9,117	A N=9,126	Rivaroxaban + Aspirin vs. Aspirin		Rivaroxaban vs. Aspirin	
	N (%)	N (%)	N (%)	HR (95% CI)	P	HR (95% CI)	P
Major bleeding	288 (3.1%)	255 (2.8%)	170 (1.9%)	1.70 (1.40-2.05)	<0.0001	1.51 (1.25-1.84)	<0.0001
Fatal	15 (0.2%)	14 (0.2%)	10 (0.1%)	1.49 (0.67-3.33)	0.32	1.40 (0.62-3.15)	0.41
Non fatal ICH*	21 (0.2%)	32 (0.4%)	19 (0.2%)	1.10 (0.59-2.04)	0.77	1.69 (0.96-2.98)	0.07
Non-fatal other critical organ*	42 (0.5%)	45 (0.5%)	29 (0.3%)	1.43 (0.89-2.29)	0.14	1.57 (0.98-2.50)	0.06

Outcome	R + A N=9,152	A N=9,126	Rivaroxaban + Aspirin vs. Aspirin	
	N (%)	N (%)	HR (95% CI)	P
Net clinical benefit (Primary + Severe bleeding events)	431 (4.7%)	534 (5.9%)	0.80 (0.70-0.91)	0.0005

En conclusion

Le principe de DATP « à la carte » après 1 an est acquis.

N'influencent le choix :
Le sexe
La génétique…
Les tests de réactivités

Influencent le choix :
Une atteinte athéromateuse TC ou IVA
ATC complexe
La molécule : ticagrelor/Rivaroxaban
Le score DAPT
Le risque hémorragique