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X I have the following potential conflicts of interest to report:

x Consulting and lecture fees: Abbott Vascular, Astra Zeneca, Boston Scientific, Crossroad Institute, Edwards, Europa Organisation, Medtronic, Terumo, Sanofi

- Employment in industry
- Stockholder of a healthcare company
- Owner of a healthcare company

I do not have any potential conflict of interest

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

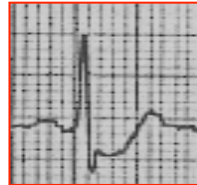
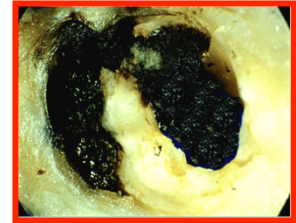
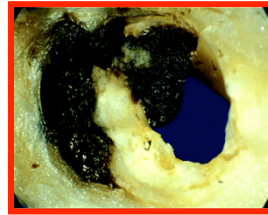
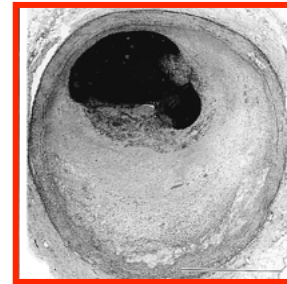
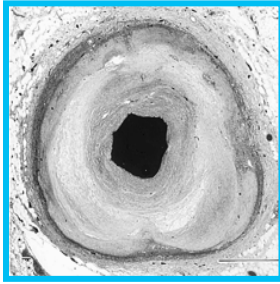
Thomas CUISSET
CHU Timone, Marseille



Une maladie, deux présentations

Syndrome Coronaire Chronique

Syndrome Coronaire aigu



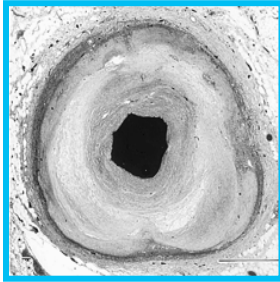
SCA non ST



SCA ST+

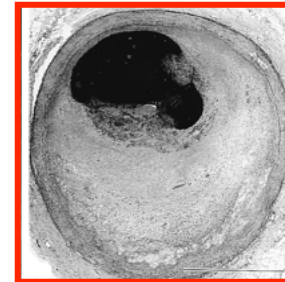
Une maladie, deux présentations

Syndrome Coronaire Chronique



Patients programmés
Patients de consultation
Tests non invasifs
Risque mortalité long terme

Syndrome Coronaire aigu



Urgences Cardiologiques
Hospitalisation
Coronarographie
Risque mortalité court terme

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

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Nouveau titre !

Démarche diagnostique

Traitement anti-ischémiques

Prévention des évènements

Revascularisation

Suivi des patients

Nouveau titre !

Démarche diagnostique

Traitement anti-ischémiques

Prévention des évènements

Revascularisation

Suivi des patients

2006
Stable Angina

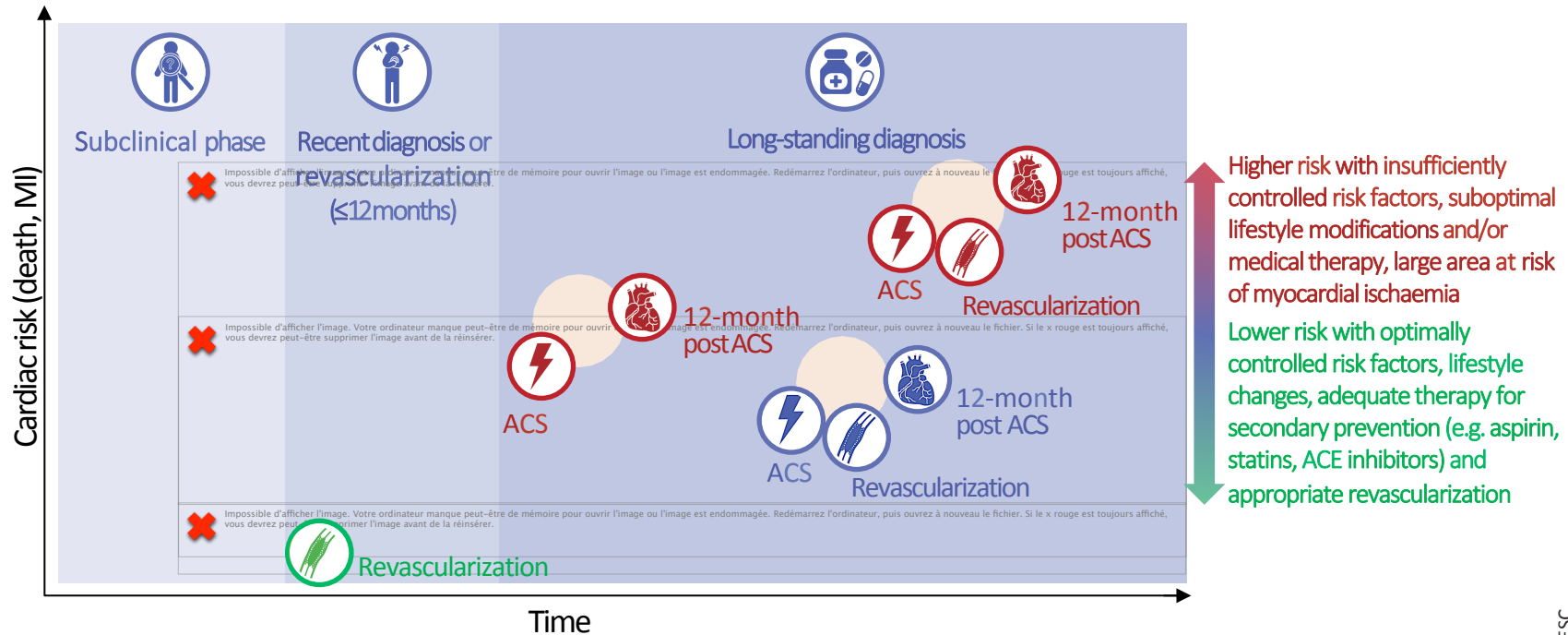


2013
Stable Coronary artery disease

2019
Chronic coronary syndromes

Natural history of chronic coronary syndromes

A dynamic process



Nouveau titre !

Démarche diagnostique

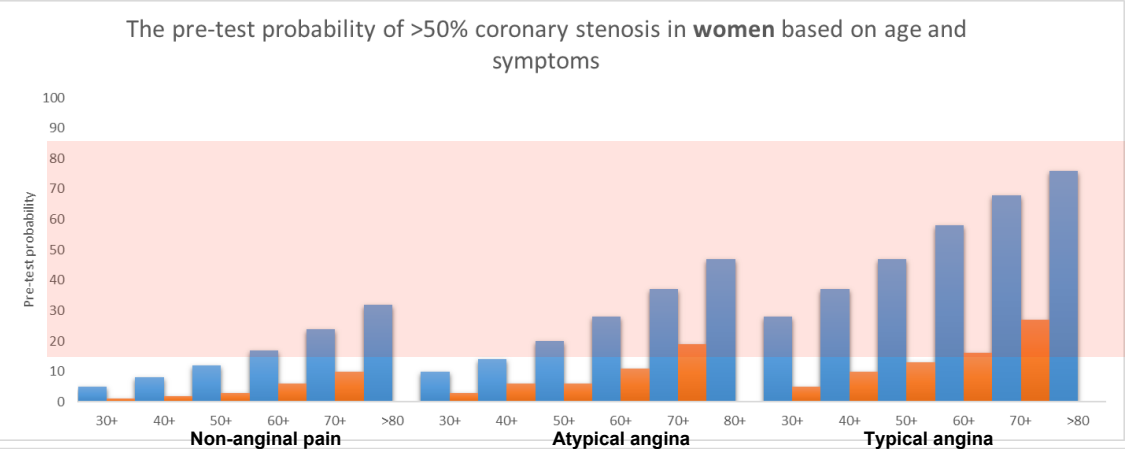
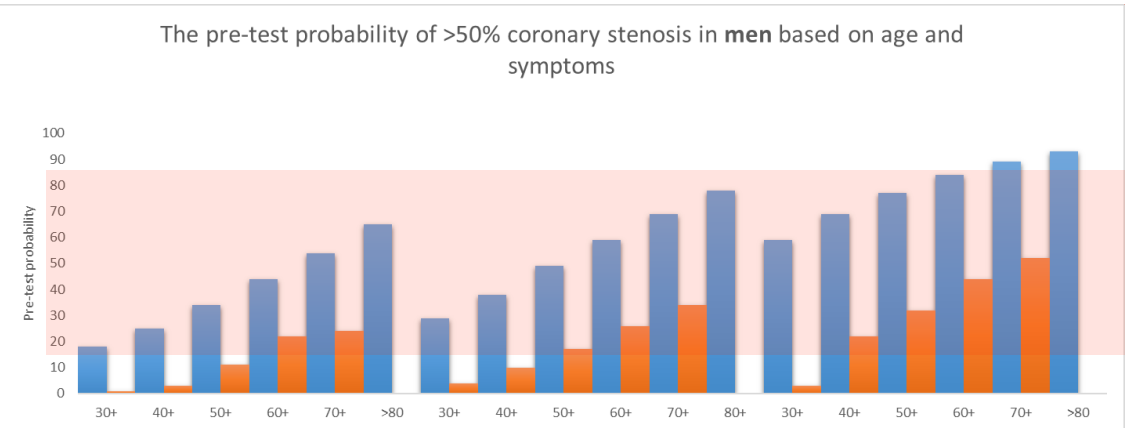
Traitement anti-ischémiques

Prévention des évènements

Revascularisation

Suivi des patients

Pre-test probability of coronary artery disease 2013 → 2019



■ *Genders et al 2011 ESC SCAD 2013 guidelines*
■ *Juarez-Orozco et al. EHJ CI 2019 ESC CCS 2019 guidelines*

In 2019 57% of pts with chest pain has PTP < 15%

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Patients with angina and/or dyspnoea and suspected coronary artery disease

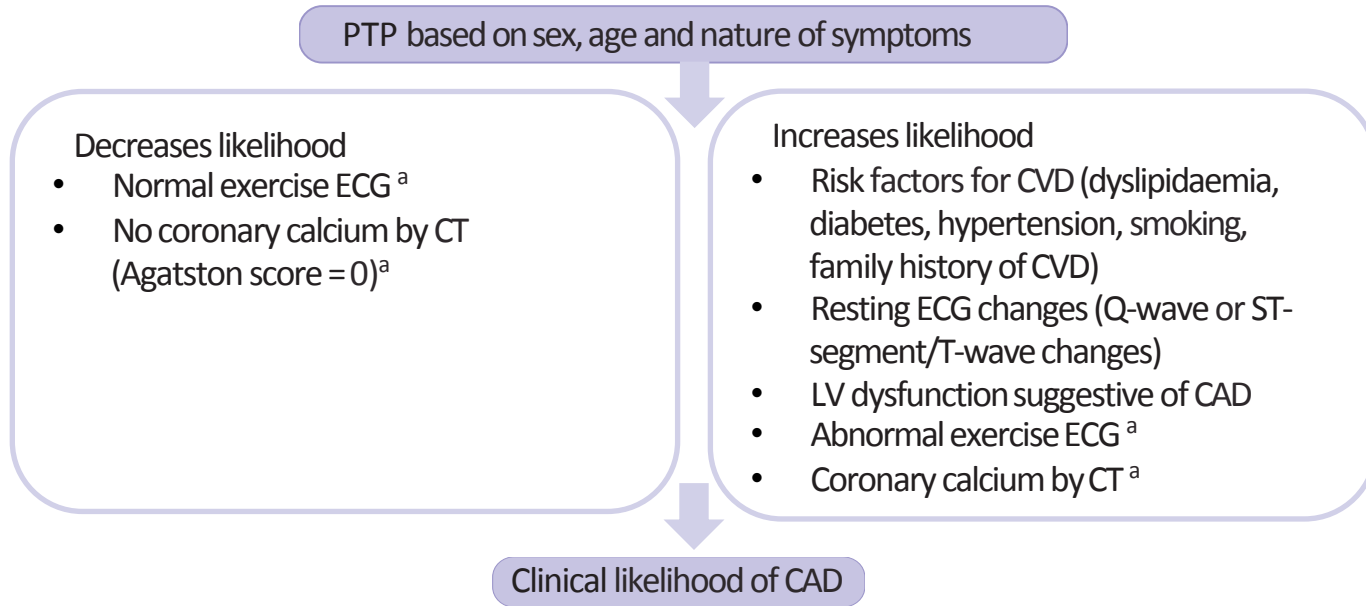
Pre-test probability of coronary artery disease

Age	Typical		Atypical		Non-anginal		Dyspnoea ^a	
	M	W	M	W	M	W	M	W
30–39	3%	5%	4%	3%	1%	1%	0%	3%
40–49	22%	10%	10%	6%	3%	2%	12%	3%
50–59	32%	13%	17%	6%	11%	3%	20%	9%
60–69	44%	16%	26%	11%	22%	6%	27%	14%
70+	52%	27%	34%	19%	24%	10%	32%	12%

^a In addition to the classic Diamond and Forrester classes, patients with dyspnoea only or dyspnoea as the primary symptom are included. The dark green shaded regions denote the groups in which non-invasive testing is most beneficial (pre-test probability >15%). The light green shaded regions denote the groups with pre-test probability of CAD between 5-15% in which the testing for diagnosis may be considered after assessing the overall clinical likelihood based on modifiers of pre-test probability.

Patients with angina and/or dyspnoea and suspected coronary artery disease

Determinants of clinical likelihood of CAD



^a if available.

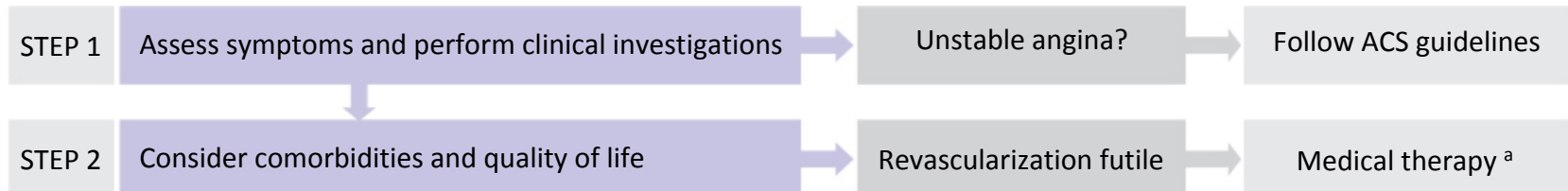
Patients with angina and/or dyspnoea and suspected coronary artery disease

Diagnostic approach (1)



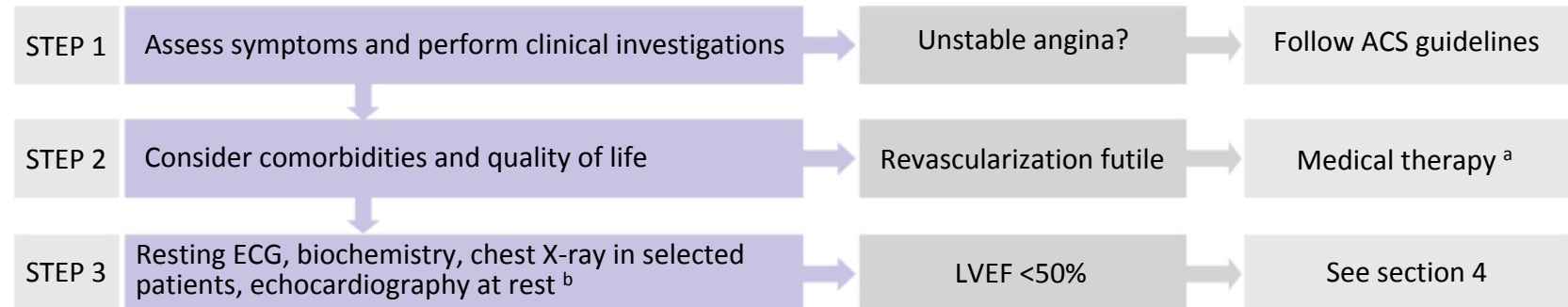
Patients with angina and/or dyspnoea and suspected coronary artery disease

Diagnostic approach (1)



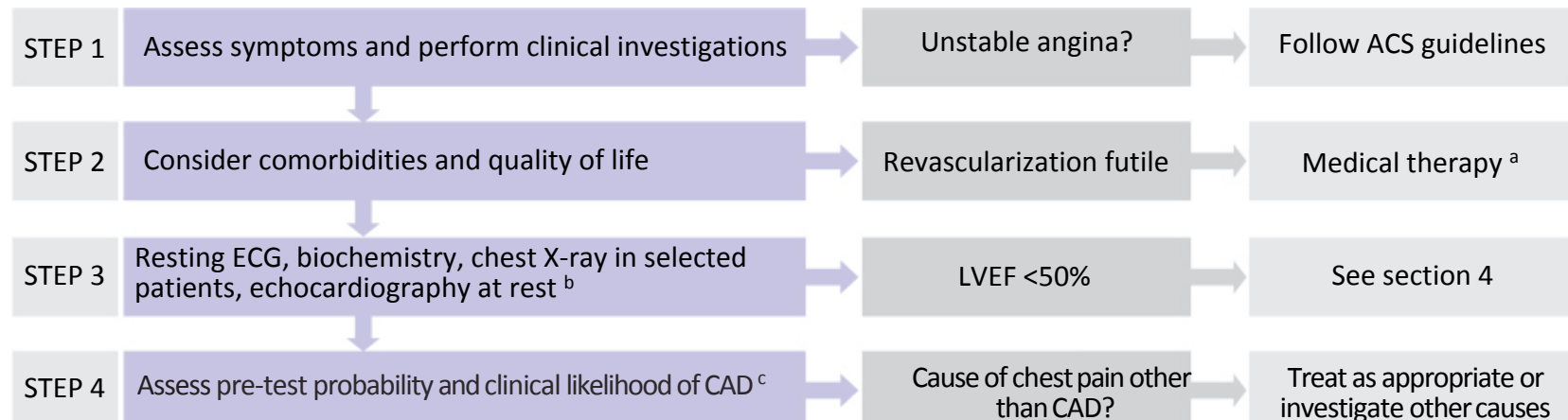
Patients with angina and/or dyspnoea and suspected coronary artery disease

Diagnostic approach (1)



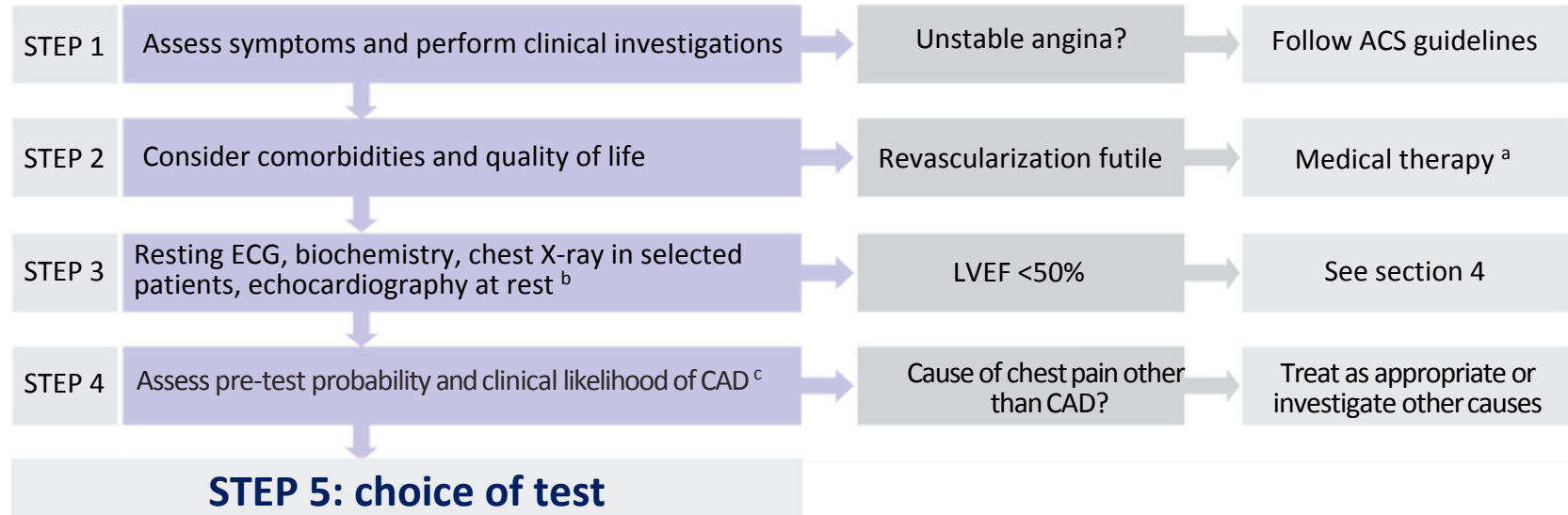
Patients with angina and/or dyspnoea and suspected coronary artery disease

Diagnostic approach (1)

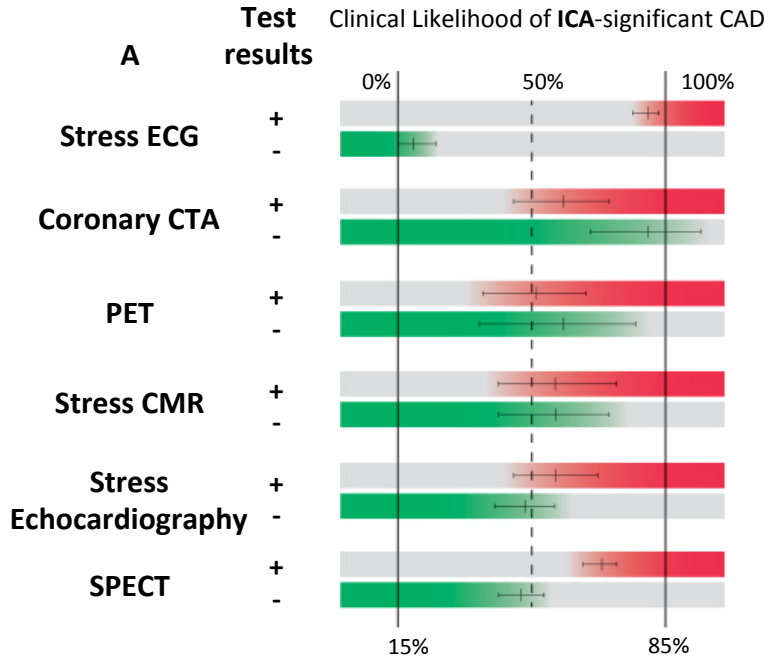


Patients with angina and/or dyspnoea and suspected coronary artery disease

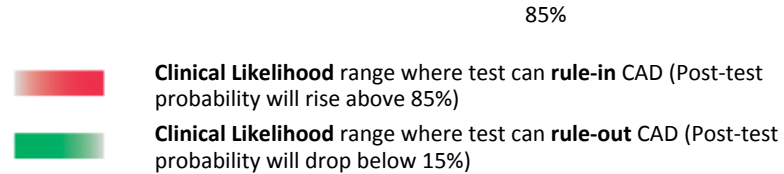
Diagnostic approach (1)



Patients with angina and/or dyspnoea and suspected coronary artery disease



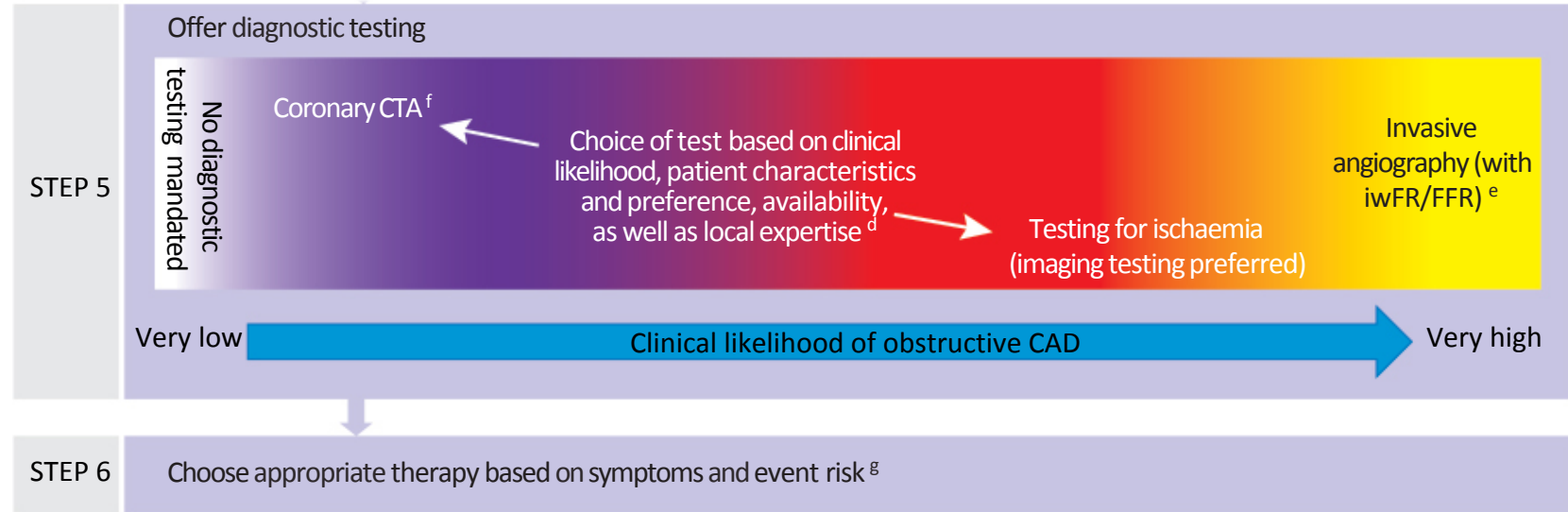
Ranges of clinical likelihood for rule-in/out CAD



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Patients with angina and/or dyspnoea and suspected coronary artery disease

Diagnostic approach (2)



Patients with angina and/or dyspnoea and suspected coronary artery disease - Use of diagnostic imaging tests (1)

Recommendations	Class	Level
Non-invasive functional imaging for myocardial ischaemia ^a or coronary CTA is recommended as the initial test to diagnose CAD in symptomatic patients in whom obstructive CAD cannot be excluded by clinical assessment alone.	I	B
It is recommended that selection of the initial non-invasive diagnostic test is done based on the clinical likelihood of CAD and other patient characteristics that influence test performance, ^b local expertise, and the availability of tests.	I	C
Functional imaging for myocardial ischaemia is recommended if coronary CTA has shown CAD of uncertain functional significance or is not diagnostic.	I	B
Invasive angiography is recommended as an alternative test to diagnose CAD in patients with a high clinical likelihood, severe symptoms refractory to medical therapy or typical angina at a low level of exercise, and clinical evaluation that indicates high event risk. Invasive functional assessment must be available and used to evaluate stenoses before revascularization, unless very high grade (>90% diameter stenosis).	I	B

^a Stress echocardiography, stress cardiac magnetic resonance, single-photon emission CT, or positron emission tomography. ^b Characteristics determining ability to exercise, likelihood of good image quality, expected radiation exposure, and risks or contraindications.

Patients with angina and/or dyspnoea and suspected coronary artery disease - Use of diagnostic imaging tests (1)

Recommendations	Class	Level
Non-invasive functional imaging for myocardial ischaemia ^a or coronary CTA is recommended as the initial test to diagnose CAD in symptomatic patients in whom obstructive CAD cannot be excluded by clinical assessment alone.	I	B
It is recommended that selection of the initial non-invasive diagnostic test is done based on the clinical likelihood of CAD and other patient characteristics that influence test performance, ^b local expertise, and the availability of tests.	I	C
Functional imaging for myocardial ischaemia is recommended if coronary CTA has shown CAD of uncertain functional significance or is not diagnostic.	I	B
Invasive angiography is recommended as an alternative test to diagnose CAD in patients with a high clinical likelihood, severe symptoms refractory to medical therapy or typical angina at a low level of exercise, and clinical evaluation that indicates high event risk. Invasive functional assessment must be available and used to evaluate stenoses before revascularization, unless very high grade (>90% diameter stenosis).	I	B

^a Stress echocardiography, stress cardiac magnetic resonance, single-photon emission CT, or positron emission tomography. ^b Characteristics determining ability to exercise, likelihood of good image quality, expected radiation exposure, and risks or contraindications.

Patients with angina and/or dyspnoea and suspected coronary artery disease - Use of diagnostic imaging tests (2)

Recommendations	Class	Level
Invasive coronary angiography with the availability of invasive functional evaluation should be considered for confirmation of the diagnosis of CAD in patients with an uncertain diagnosis on non-invasive testing.	IIa	B
Coronary CTA should be considered as an alternative to invasive angiography if another non-invasive test is equivocal or non-diagnostic.	IIa	C
Coronary CTA is not recommended when extensive coronary calcification, irregular heart rate, significant obesity, inability to cooperate with breath-hold commands, or any other conditions make obtaining good image quality unlikely.	III	C
Coronary calcium detection by CT is not recommended to identify individuals with obstructive CAD.	III	C

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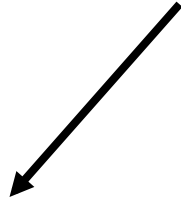
Patients with angina and/or dyspnoea and suspected coronary artery disease

Use of exercise electrocardiogram

Recommendations	Class	Level
Exercise ECG is recommended for the assessment of exercise tolerance, symptoms, arrhythmias, BP response, and event risk in selected patients. ^a	I	C
Exercise ECG may be considered as an alternative test to rule-in or rule-out CAD when non-invasive imaging is not available.	IIb	B
Exercise ECG may be considered in patients on treatment to evaluate control of symptoms and ischaemia.	IIb	C
Exercise ECG is not recommended for diagnostic purposes in patients with ≥ 0.1 mV ST-segment depression on resting ECG or who are being treated with digitalis.	III	C

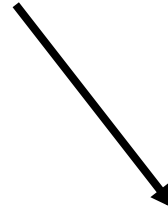
^a When this information will have an impact on diagnostic strategy or management.

Traitement Syndrome Coronaire Chronique



Traitement si Symptômes 'Angor stable'

TTT anti-ischémique
Revascularisation



Traitement Maladie 'Eviter événements'

Prévention
Mode de vie
Médicaments

Nouveau titre !

Démarche diagnostique

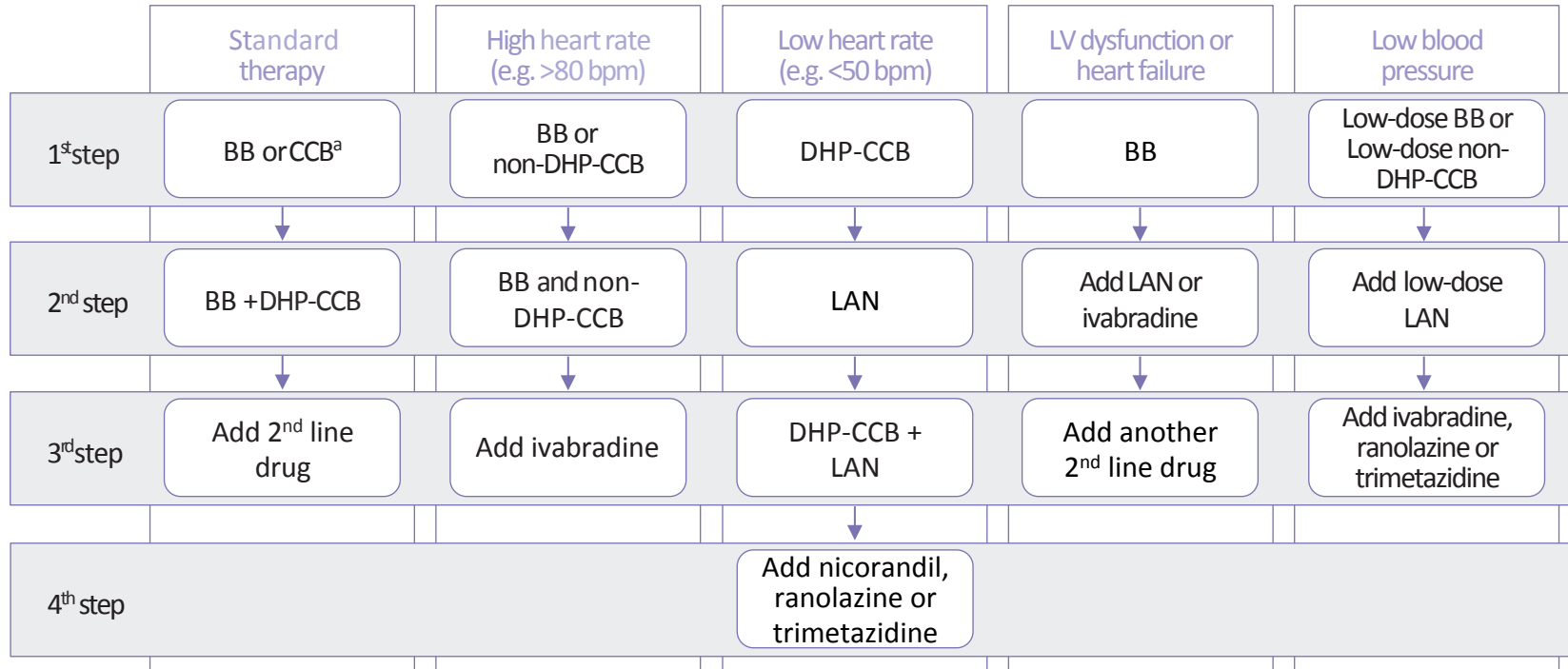
Traitement anti-ischémiques

Prévention des évènements

Revascularisation

Suivi des patients

Patients with angina and/or dyspnoea and coronary artery disease - Long term anti-ischaemic drug therapy



^a Combination of a BB with a DHP-CCB should be considered as first step; combination of a BB or a CCB with a second-line drug may be considered as a first step.

Nouveau titre !

Démarche diagnostique

Traitement anti-ischémiques

Prévention des évènements

Revascularisation

Suivi des patients

Cas Clinique

Homme 55 ans

Tabac, DT2, Hchol

IDM antérieur H3
DES IVA puis Mg et CD

FEVG 45%
DAPT par ASA + Ticagrelor

A 1 an (« CCS patient »)

Pas de sevrage tabagique

HBA1c 8.5%

LDL chol 1.3 sous Tahor 40 mg

Pas de problème hémorragique

Comment prévenir les SCA futurs ?

Life Style Recommendations

Key for Event Prevention

Patients with angina and/or dyspnoea and coronary artery disease

Lifestyle recommendations

Smoking cessation	Use pharmacological and behavioural strategies to help patients quit smoking. Avoid passive smoking.
Healthy diet	Diet high in vegetables, fruit, and wholegrains. Limit saturated fat to <10% of total intake. Limit alcohol to <100 g/week or 15 g/day.
Physical activity	30 - 60 min moderate physical activity most days, but even irregular activity is beneficial.
Healthy weight	Obtain and maintain a healthy weight (<25 kg/m ²), or reduce weight through recommended energy intake and increased physical activity.
Other	Take medications as prescribed. Sexual activity is low risk for stable patients not symptomatic at low-to-moderate activity levels.

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Antithrombotic Strategy

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (1)

Recommendations	Class	Level
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.	I	A
Clopidogrel 75 mg daily is recommended as an alternative to aspirin in patients with aspirin intolerance.	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.	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

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Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (2)

Recommendations	Class	Level
Antithrombotic therapy in patients with CCS and in sinus rhythm		
Adding a second antithrombotic drug to aspirin for long-term secondary prevention should be considered in patients with high risk of ischaemic events ^a and without high bleeding risk. ^b	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 ^c and without high bleeding risk. ^b	IIb	A

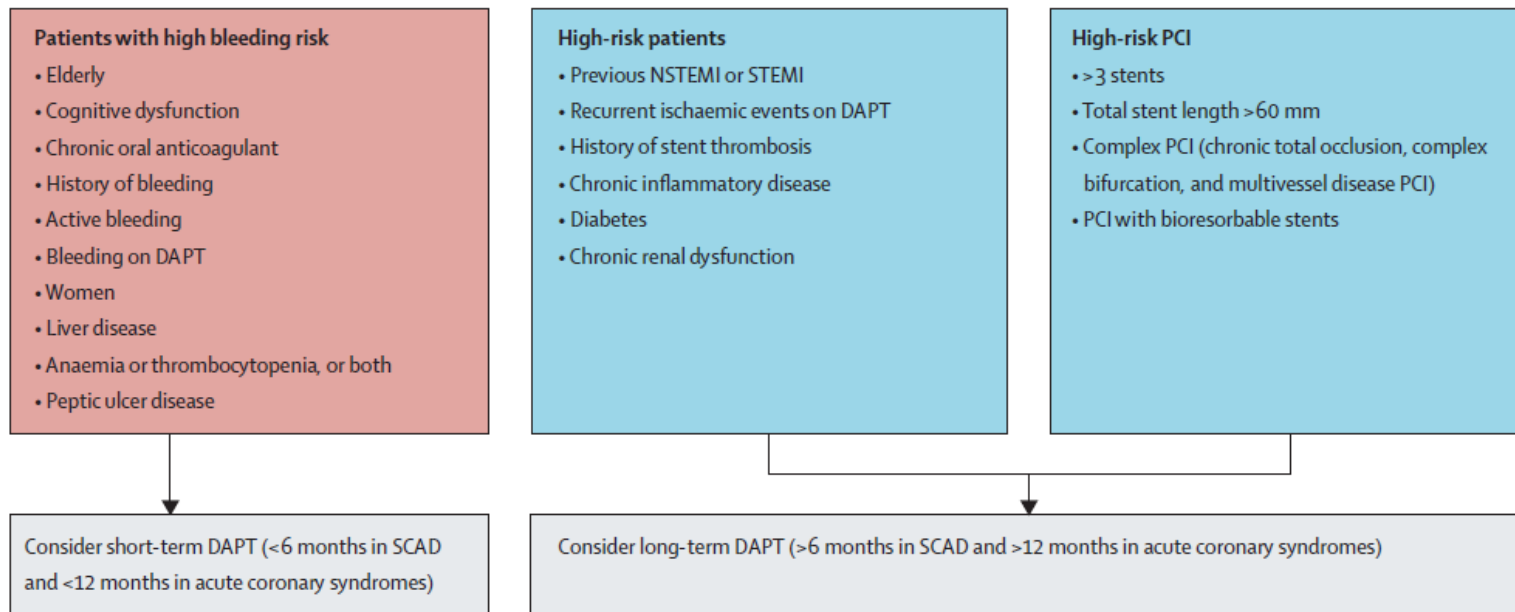
^a Diffuse multivessel CAD with at least one of the following: diabetes mellitus requiring medication, recurrent MI, PAD, or CKD with eGFR 15-59 mL/min/1.73 m².

^b Prior history of intracerebral haemorrhage or ischaemic stroke, history of other intracranial pathology, recent gastrointestinal bleeding or anaemia due to possible gastrointestinal blood loss, other gastrointestinal pathology associated with increased bleeding risk, liver failure, bleeding diathesis or coagulopathy, extreme old age or frailty, or renal failure requiring dialysis or with eGFR <15 mL/min/1.73 m².

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (2)

- ^a Diffuse multivessel CAD with at least one of the following: diabetes mellitus requiring medication, recurrent MI, PAD, or CKD with eGFR 15-59 mL/min/1.73 m².
- ^b Prior history of IC haemorrhage or ischaemic stroke, history of other IC pathology, recent GI bleeding or anaemia due to possible GI blood loss, other GI pathology associated with increased bleeding risk, liver failure, bleeding diathesis or coagulopathy, extreme old age or frailty, or renal failure requiring dialysis or with eGFR <15 mL/min/1.73 m².

DAPT duration: Patient identification



« **Less DAPT** »

« **More DAPT** »

Patients with angina and/or dyspnoea and coronary artery disease

Treatment options for dual antithrombotic therapy

Drug option	Dose	Indication	Additional cautions
Clopidogrel	75 mg o.d.	Post-MI in patients who have tolerated DAPT for 1 year	
Prasugrel	10 mg o.d. or 5 mg o.d. if body weight <60 kg or age >75 years	Post-PCI for MI in patients who have tolerated DAPT for 1 year	Age >75 years
Rivaroxaban	2.5 mg b.i.d.	Post-MI >1 year or multivessel CAD	Creatinine clearance 15-29 mL/min
Ticagrelor	60 mg b.i.d.	Post-MI in patients who have tolerated DAPT for 1 year	

Treatment options for dual antithrombotic therapy in combination with aspirin 75-100 mg daily are reported for patients who have a high or moderate risk of ischaemic events, and do not have a high bleeding risk.

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Stratégie antithrombotique optimisée au-delà 1 an

Options en sus de l'aspirine... en France !

Ticagrelor 60 mg (Etude PEGASUS): Pas de remboursement

Rivaroxaban 2,5 mg (Etude COMPASS): Pas de remboursement

Donc on fait quoi ? ... moi en pratique, je fais du Duoplavin ...

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (3)

Recommendations	Class	Level
Antithrombotic therapy post-PCI in patients with CCS and in sinus rhythm		
Aspirin 75-100 mg daily is recommended following stenting.	I	A
Clopidogrel 75 mg daily following appropriate loading (e.g. 600 mg or >5 days of maintenance therapy) is recommended , in addition to aspirin, for 6 months following coronary stenting, irrespective of stent type, unless a shorter duration (1-3 months) is indicated due to risk or the occurrence of life-threatening bleeding.	I	A
Clopidogrel 75 mg daily following appropriate loading (e.g. 600 mg or >5 days of maintenance therapy) should be considered for 3 months in patients with a higher risk of life-threatening bleeding.	IIa	A

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Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (4)

Recommendations	Class	Level
Antithrombotic therapy post-PCI in patients with CCS and in sinus rhythm		
Clopidogrel 75 mg daily following appropriate loading (e.g. 600 mg or >5 days of maintenance therapy) may be considered for 1 month in patients with very high risk of life-threatening bleeding.	IIb	C
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

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Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (5)

Recommendations	Class	Level
Antithrombotic therapy in patients with CCS and AF		
When oral anticoagulation is initiated in a patient with AF who is eligible for a NOAC, ^a a NOAC is recommended in preference to a VKA.	I	A

^a See Summary of Product Characteristics for reduced doses or contraindications for each NOAC in patients with CKD, body weight <60 kg, age >75–80 years, and/or drug interactions.

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (6)

Recommendations	Class	Level
Antithrombotic therapy in patients with CCS and AF		
Aspirin 75-100 mg daily (or clopidogrel 75 mg daily) may be considered in addition to long-term OAC therapy in patients with AF, history of MI, and at high risk of recurrent ischaemic events ^b who do not have a high bleeding risk. ^c	IIb	B

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (7)

Recommendations	Class	Level
Antithrombotic therapy in post-PCI patients with AF or another indication for an OAC		
It is recommended that peri-procedural aspirin and clopidogrel are administered to patients undergoing coronary stent implantation.	I	C
In patients who are eligible for a NOAC , it is recommended that a NOAC (apixaban 5 mg b.i.d., dabigatran 150 mg b.i.d., edoxaban 60 mg o.d., or rivaroxaban 20 mg o.d.) ^a is used in preference to a VKA in combination with antiplatelet therapy.	I	A

^a See summary of product characteristics for reduced doses or contraindications for each NOAC in patients with CKD, body weight <60 kg, age >75-80 years, and/or drug interactions.

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (8)

Recommendations	Class	Level
Antithrombotic therapy in post-PCI patients with AF or another indication for an OAC		
When rivaroxaban is used and concerns about high bleeding risk ^a prevail over concerns about stent thrombosis ^b or ischaemic stroke, ^c rivaroxaban 15 mg o.d. should be considered in preference to rivaroxaban 20 mg o.d. for the duration of concomitant single or dual antiplatelet therapy.	IIa	B
When dabigatran is used and concerns about high bleeding risk ^a prevail over concerns about stent thrombosis ^b or ischaemic stroke, ^c dabigatran 110 mg b.i.d. should be considered in preference to dabigatran 150 mg b.i.d. for the duration of concomitant single or dual antiplatelet therapy.	IIa	B

^a Prior history of intracerebral haemorrhage or ischaemic stroke, history of other intracranial pathology, recent gastrointestinal bleeding or anaemia due to possible gastrointestinal blood loss, other gastrointestinal pathology associated with increased bleeding risk, liver failure, bleeding diathesis or coagulopathy, extreme old age or frailty, or renal failure requiring dialysis or with eGFR <15 mL/min/1.73 m². ^b Risk of stent thrombosis encompasses (i) the risk of thrombosis occurring and (ii) the risk of death should stent thrombosis occur, both of which relate to anatomical, procedural, and clinical characteristics. Risk factors for CCS patients include stenting of left main stem, proximal LAD, or last remaining patent artery; suboptimal stent deployment; stent length >60 mm; diabetes mellitus; CKD; bifurcation with two stents implanted; treatment of chronic total occlusion; and previous stent thrombosis on adequate antithrombotic therapy. ^c Congestive HF, hypertension, age ≥75 years (2 points), diabetes, prior stroke/transient ischaemic attack/embolus (2 points), vascular disease (CAD on imaging or angiography, prior MI, PAD, or aortic plaque), age 65-74 years, and female sex.

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (9)

Recommendations	Class	Level
Antithrombotic therapy in post-PCI patients with AF or another indication for an OAC		
After uncomplicated PCI, early cessation (≤ 1 week) of aspirin and continuation of dual therapy with an OAC and clopidogrel should be considered if the risk of stent thrombosis ^a is low, or if concerns about bleeding risk prevail over concerns about the risk of stent thrombosis, ^a irrespective of the type of stent used.	Ila	B
Triple therapy with aspirin, clopidogrel, and an OAC for ≥ 1 month should be considered when the risk of stent thrombosis ^a outweighs the bleeding risk, with the total duration (≤ 6 months) decided according to assessment of these risks and clearly specified at hospital discharge.	Ila	C

^a Risk of stent thrombosis encompasses (i) the risk of thrombosis occurring and (ii) the risk of death should stent thrombosis occur, both of which relate to anatomical, procedural, and clinical characteristics. Risk factors for CCS patients include stenting of left main stem, proximal LAD, or last remaining patent artery; suboptimal stent deployment; stent length >60 mm; diabetes mellitus; CKD; bifurcation with two stents implanted; treatment of chronic total occlusion; and previous stent thrombosis on adequate antithrombotic therapy.

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (10)

Recommendations	Class	Level
Antithrombotic therapy in post-PCI patients with AF or another indication for an OAC		
Dual therapy with an OAC and either ticagrelor or prasugrel may be considered as an alternative to triple therapy with an OAC, aspirin, and clopidogrel in patients with a moderate or high risk of stent thrombosis, ^a irrespective of the type of stent used.	IIb	C
The use of ticagrelor or prasugrel is not recommended as part of triple antithrombotic therapy with aspirin and an OAC.	III	C

^a Risk of stent thrombosis encompasses (i) the risk of thrombosis occurring and (ii) the risk of death should stent thrombosis occur, both of which relate to anatomical, procedural, and clinical characteristics. Risk factors for CCS patients include stenting of left main stem, proximal LAD, or last remaining patent artery; suboptimal stent deployment; stent length >60 mm; diabetes mellitus; CKD; bifurcation with two stents implanted; treatment of chronic total occlusion; and previous stent thrombosis on adequate antithrombotic therapy.

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (11)

Recommendations	Class	Level
Use of proton-pump inhibitors		
Concomitant use of a proton-pump inhibitor is recommended in patients receiving aspirin monotherapy, DAPT, or OAC monotherapy who are at high risk of gastrointestinal bleeding.	I	A

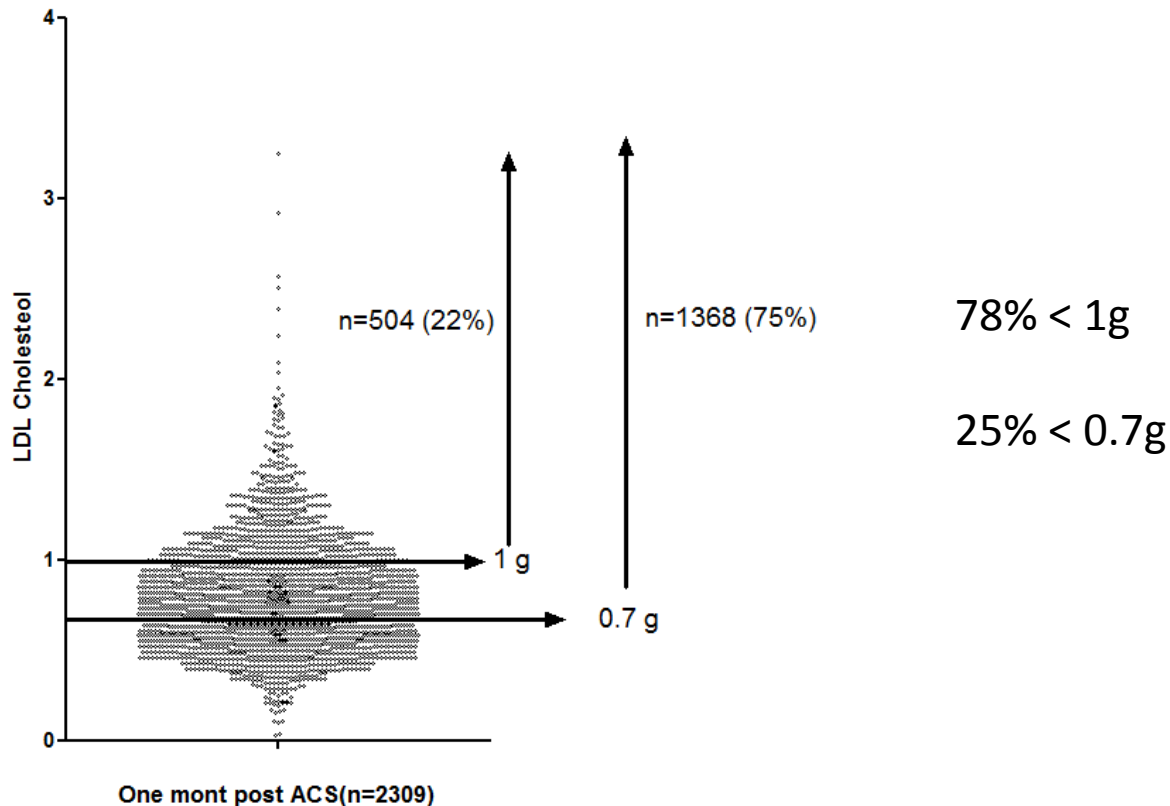
Lipid-lowering Drugs and others

Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (12)

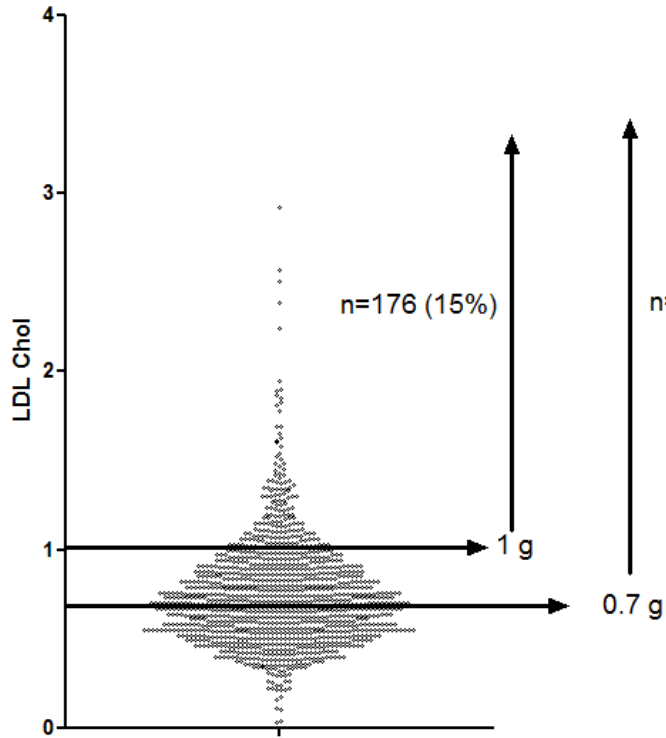
Recommendations	Class	Level
Lipid-lowering drugs		
Statins are recommended in all patients with CCS.	I	A
If a patient's goal is not achieved with the maximum tolerated dose of statin, combination with ezetimibe is recommended .	I	B
For patients at very high risk who do not achieve their goal on a maximum tolerated dose of statin and ezetimibe, a combination with a PCSK9 inhibitor is recommended .	I	A

IA dans Recommandations ESC vs ASMR 5 en France !!

Consultation « post SCA 1 mois »



Consultation « post SCA 1 mois » Forte dose Statines



N = 1157

50% patients avec LDL > 70 mg/L

15% patients avec LDL > 100 mg/L

One month post ACS with High Dose statin
Crestor 20/40, Tahor 80 or Inegy 10/40
(n=1157, 50% of Global population)

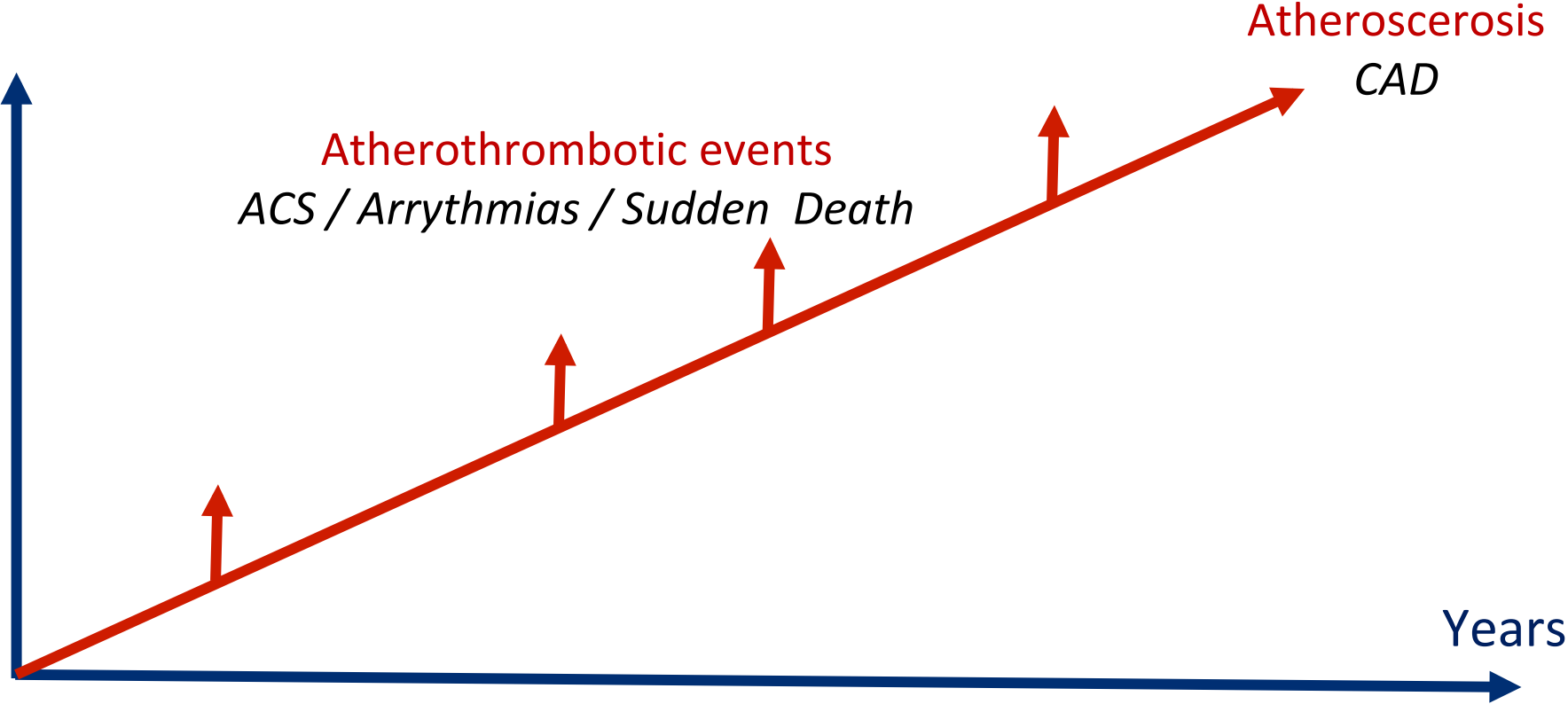
Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (12)

Recommendations	Class	Level
ACE inhibitors		
ACE inhibitors (or ARBs) are recommended if a patient has other conditions (e.g. heart failure, hypertension, or diabetes).	I	A
ACE inhibitors should be considered in CCS patients at very high risk of cardiovascular events.	IIa	A

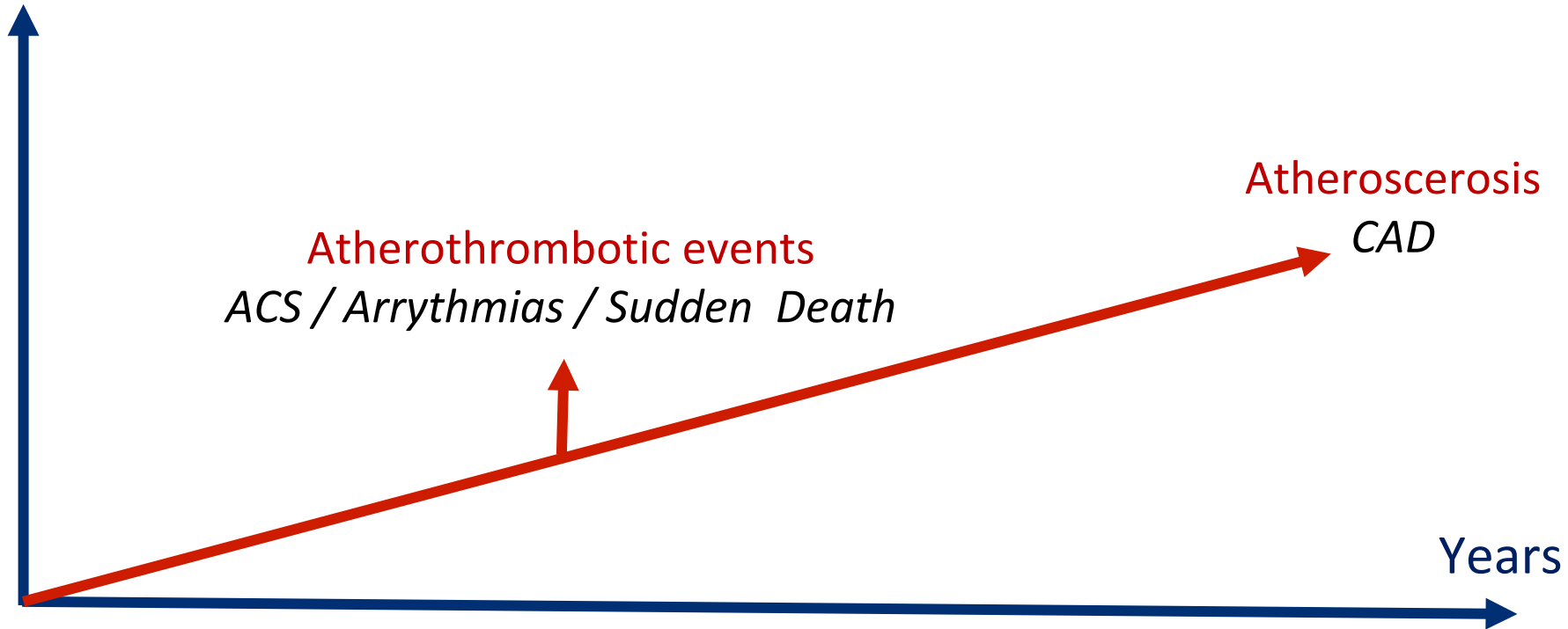
Patients with angina and/or dyspnoea and coronary artery disease - Event prevention (13)

Recommendations	Class	Level
Beta-blockers are recommended in patients with LV dysfunction or systolic HF	I	A
In patients with a previous STEMI, long-term oral treatment with a beta-blocker should be considered .	Ila	B

Poor Secondary Event Prevention



Good Secondary Event Prevention



Cas clinique

Homme 55 ans

Tabac, DT2, Hchol

IDM antérieur H3
DES IVA puis Mg et CD

FEVG 45%
DAPT par ASA + Ticagrelor

A 1 an (« CCS patient »)

Pas de sevrage tabagique

HBA1c 8.5%

LDL chol 1.8 sous Tahor 40 mg

Pas de problème hémorragique

Comment prévenir les SCA futurs ?

Arrêt tabac (aides +++), mode vie adapté

Stratégie antithrombotique optimisée au-delà 1 an

Haut risque ischémique / Bas risque hémorragique
Bonne tolérance 1 an

Atteinte cible **LDL**: Majorer statines +/- Ezetimibe

Contrôle du **Diabète**

Stratégies AAP dans maladie coronaire

DAPT after DES for CCS

When to do « less »?

Shorter duration

3 Mo in HBR patients

1 Mo in very HBR patients

Standard post PCI

ASA + Clopidogrel

Duration = 6 Mo

When to do « more » ?

Early Potent P2Y12 blockers

Ticagrelor or Prasugrel

In High risk patients / PCI

Followed by de-escalation

Longer duration

> 6 Mo in High risk patients

DAPT after ACS

When to do « less »?

ASA + Clopidogrel
In HBR patients

Shorter duration

3 to 6 Mo in HBR patients

1 Mo in very HBR patients

Standard post ACS

ASA + Potent P2Y12 1 Mo
(Prasugrel)

Followed by de-escalation
ASA + Clopidogrel 11 Mo

Duration = 12 Mo

When to do « more » ?

ASA + Prasugrel 12 Mo
No de-escalation during first year

In High risk patient

Longer DAPT duration

12 Mo in High risk patients

ASA + Clopidogrel

Plan

Nouveau titre !

Démarche diagnostique

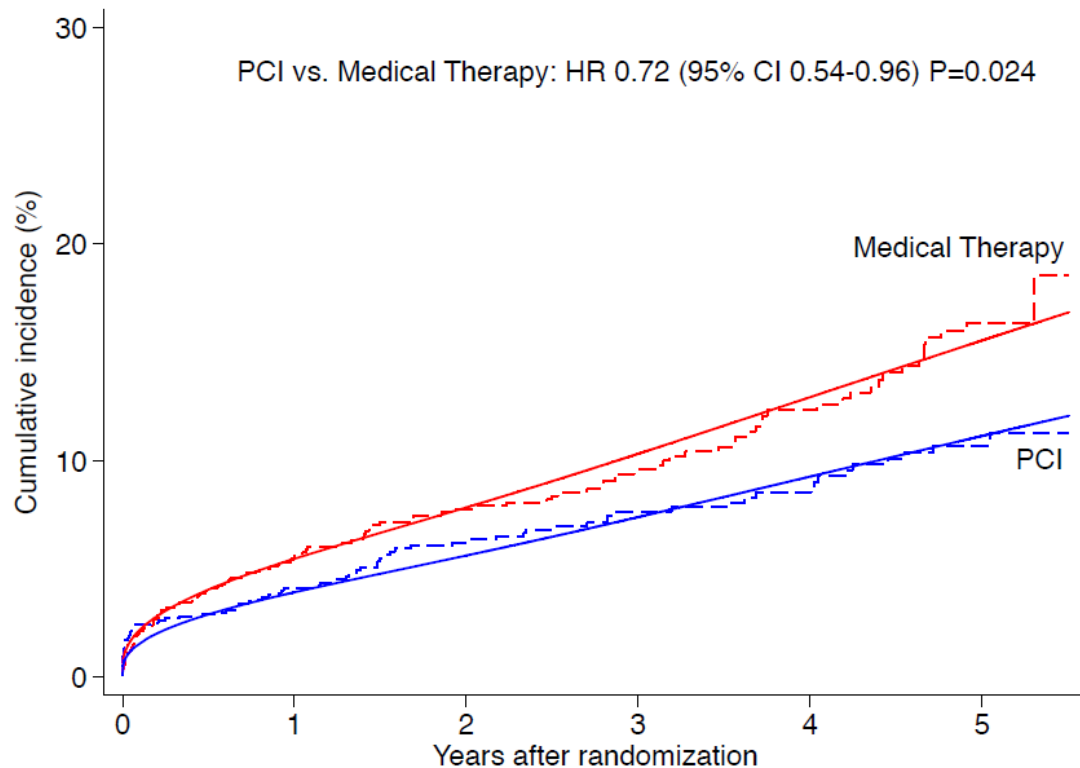
Traitement anti-ischémiques

Prévention des évènements

Revascularisation

Suivi des patients

Cardiac Death or Myocardial Infarction

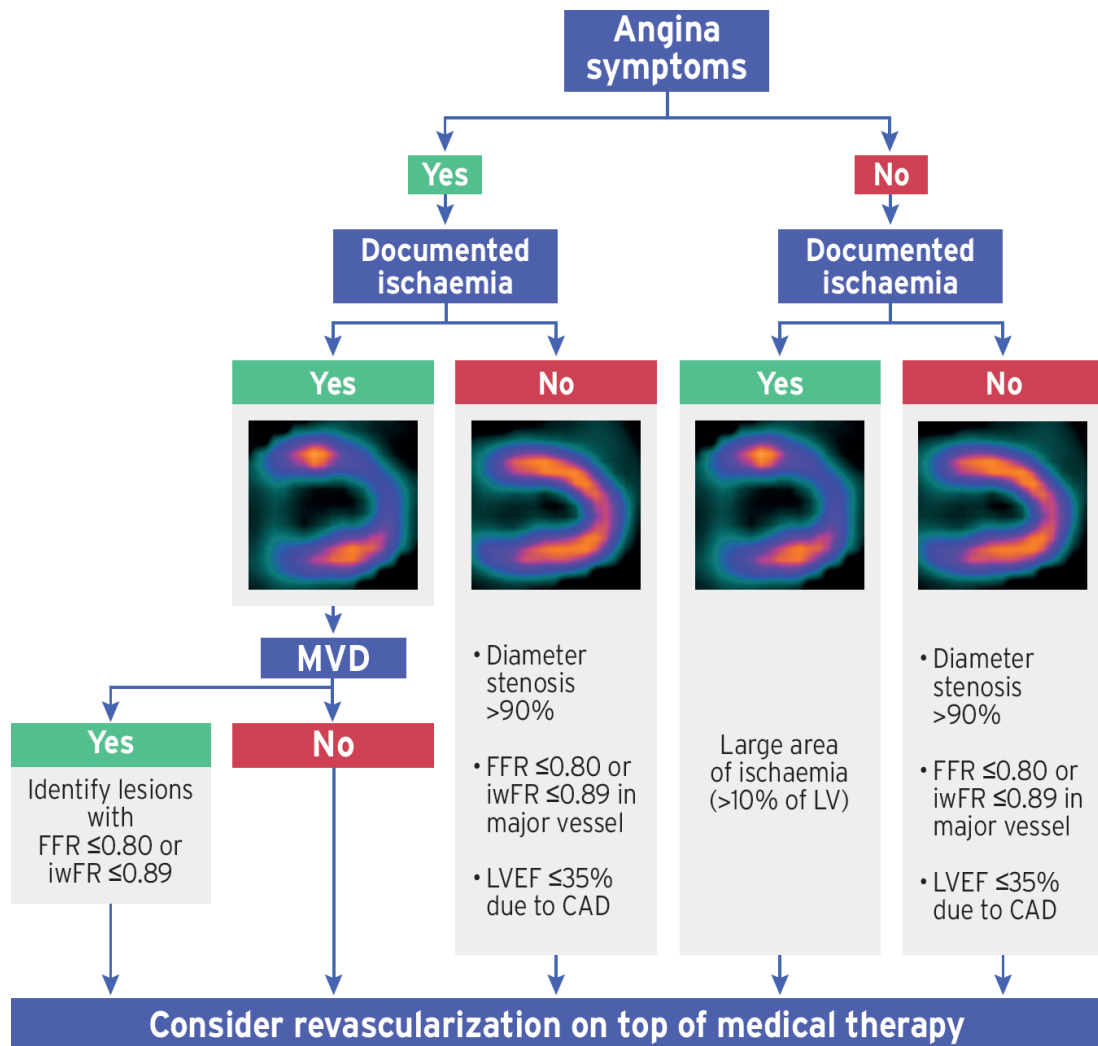


**Reduction in Spontaneous MI
with FFR-guided stenting**

28% lower (relative)

4.5% lower (absolute)

*Relative benefit of FFR-guided PCI
not different among studies

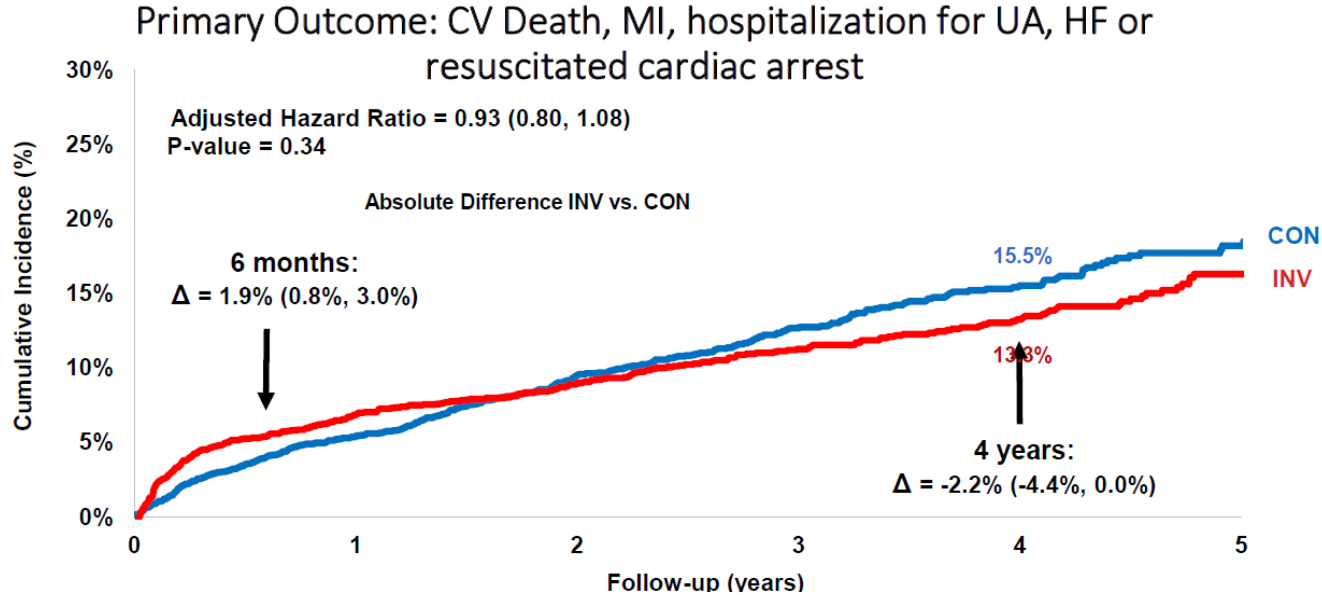


Impact étude ISCHEMIA sur les recommandations ? *(AHA Novembre 2019)*



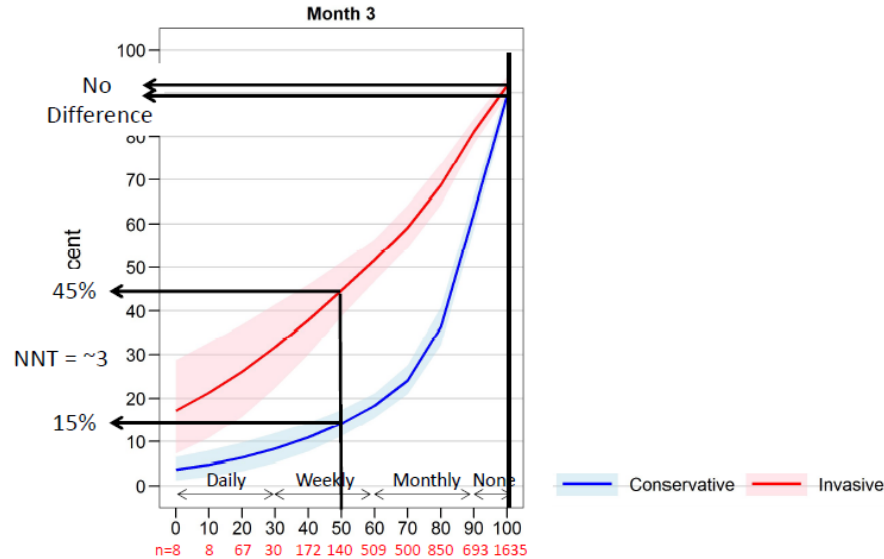
**International Study Of Comparative Health Effectiveness
With Medical And Invasive Approaches (ISCHEMIA):**

Primary Endpoint



Pas de différence

« Quality of Life » report: Angor



Bénéfice selon Angor de base

Plan

Nouveau titre !

Démarche diagnostique

Traitement anti-ischémiques

Prévention des évènements

Revascularisation

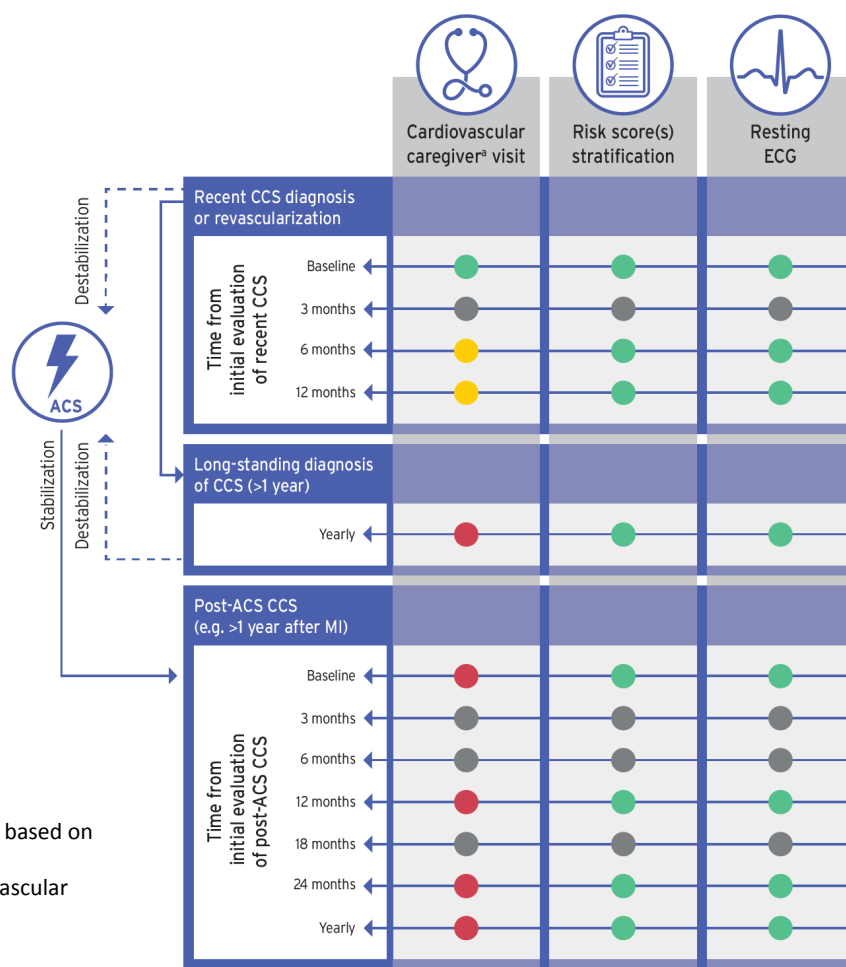
Suivi des patients

Patients with a long-standing diagnosis of chronic coronary syndromes Follow-up (1)

- Time for decision making on optional dual antithrombotic therapy
- Time for decision making on DAPT continuation in PCI patients
- Advisable timepoint
- Optional timepoint

The frequency of follow-up may be subject to variation based on clinical judgement.

^a Cardiologist, internist, general practitioner, or cardiovascular nurse.



Patients with a long-standing diagnosis of chronic coronary syndromes - Follow-up (2)



Echocardiography
at rest

Early (e.g. 1-3 months) after revascularization to set as a reference and/or periodically (e.g. at 1 year if previously abnormal and/or **every 3-5 years**) to evaluate LV function, valvular status and haemodynamic status.



Stress test for
inducible ischaemia

As necessary, to investigate changes in symptoms level, and/or early (e.g. 1-3 months) after revascularization to set as a reference



Invasive coronary
angiography

As necessary, for patients at high risk based on noninvasive ischaemia testing, or severe angina symptoms (e.g. CCS class 3-4).
Not recommended solely for risk stratification.

Plan

Nouveau titre !

Chronic Coronary syndrome

Démarche diagnostique

Plus de Coroscanner, moins d'épreuve effort « simple ECG »

Traitement anti-ischémiques

BB et Anti Ca première ligne / Nitrés seconde ligne

Prévention des évènements

Mode vie / Stratégie antithrombotique optimisée / LDL au plus bas

Revascularisation

Bénéfice symptôme... aussi sur critères durs ?

Suivi des patients

Cs annuelle, ETT et test non invasif au cas par cas

www.escardio.org/guidelines

**Full Text
ESC Pocket Guidelines App
and much more...**

