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Insuffisance cardiaque

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www.escardio.org/ESC2022
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L’insuffisance cardiaque à l’ESC 2022

- ADVOR
- REVIVED-BCIS2
- DELIVER
- PERSPECTIVE

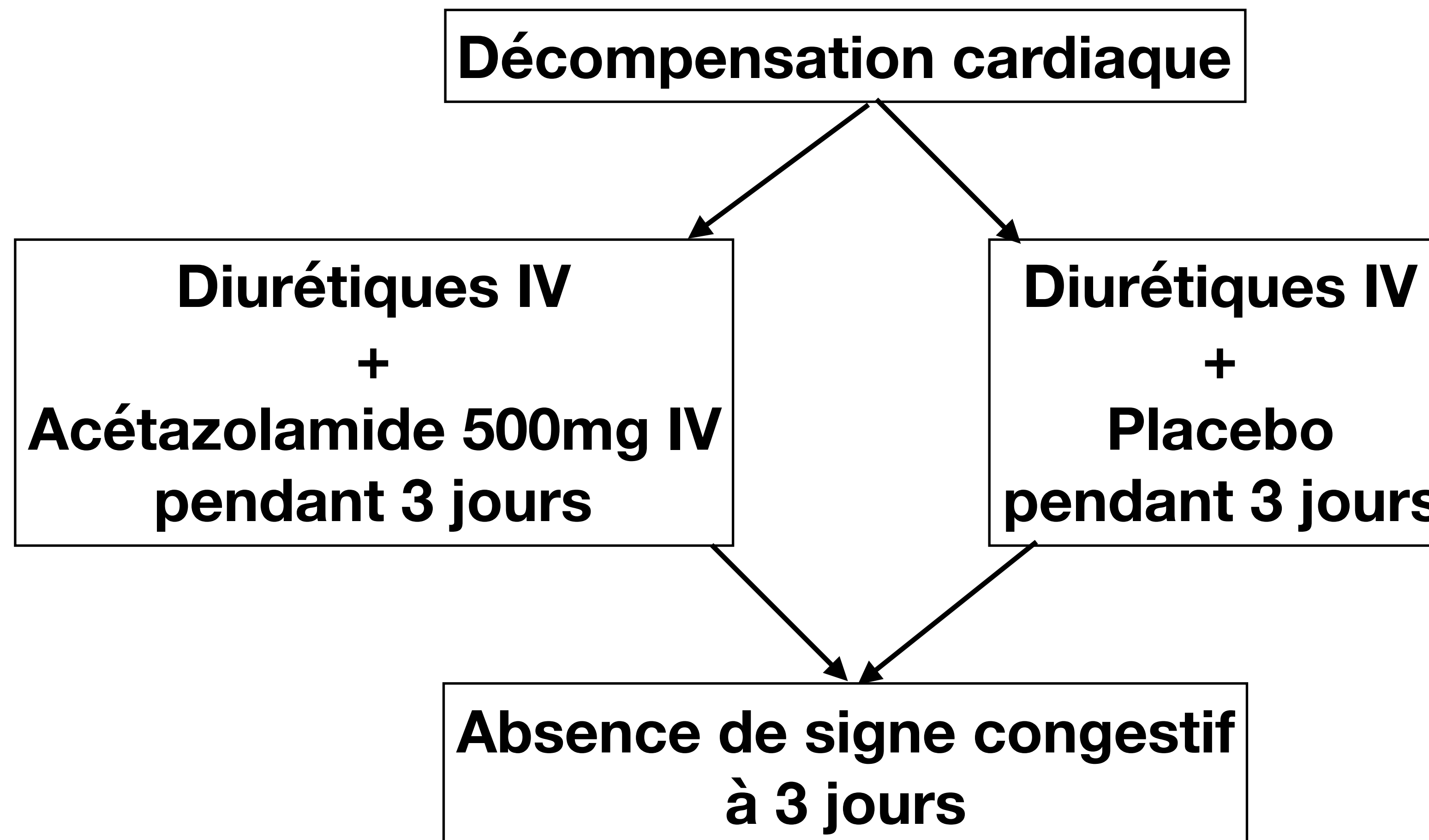
ADVOR

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Acetazolamide in Acute Decompensated Heart Failure with Volume Overload

W. Mullens, J. Dauw, P. Martens, F.H. Verbrugge, P. Nijst, E. Meekers, K. Tartaglia, F. Chenot, S. Moubayed, R. Dierckx, P. Blouard, P. Troisfontaines, D. Derthoo, W. Smolders, L. Bruckers, W. Droogne, J.M. Ter Maaten, K. Damman, J. Lassus, A. Mebazaa, G. Filippatos, F. Ruschitzka, and M. Dupont, for the ADVOR Study Group*



ADVOR

- ACETAZOLAMIDE = bloque la résorption de sodium dans le tubule proximal
- Inclusion : signes congestifs + BNP/NTproBNP élevé + au moins 40mg de furosémide dans le traitement de fond
- Exclusion : traitement par acétazolamide ou inhibiteur de SGLT2 / TAs <90mmHg / DFG <20ml/min

ADVOR

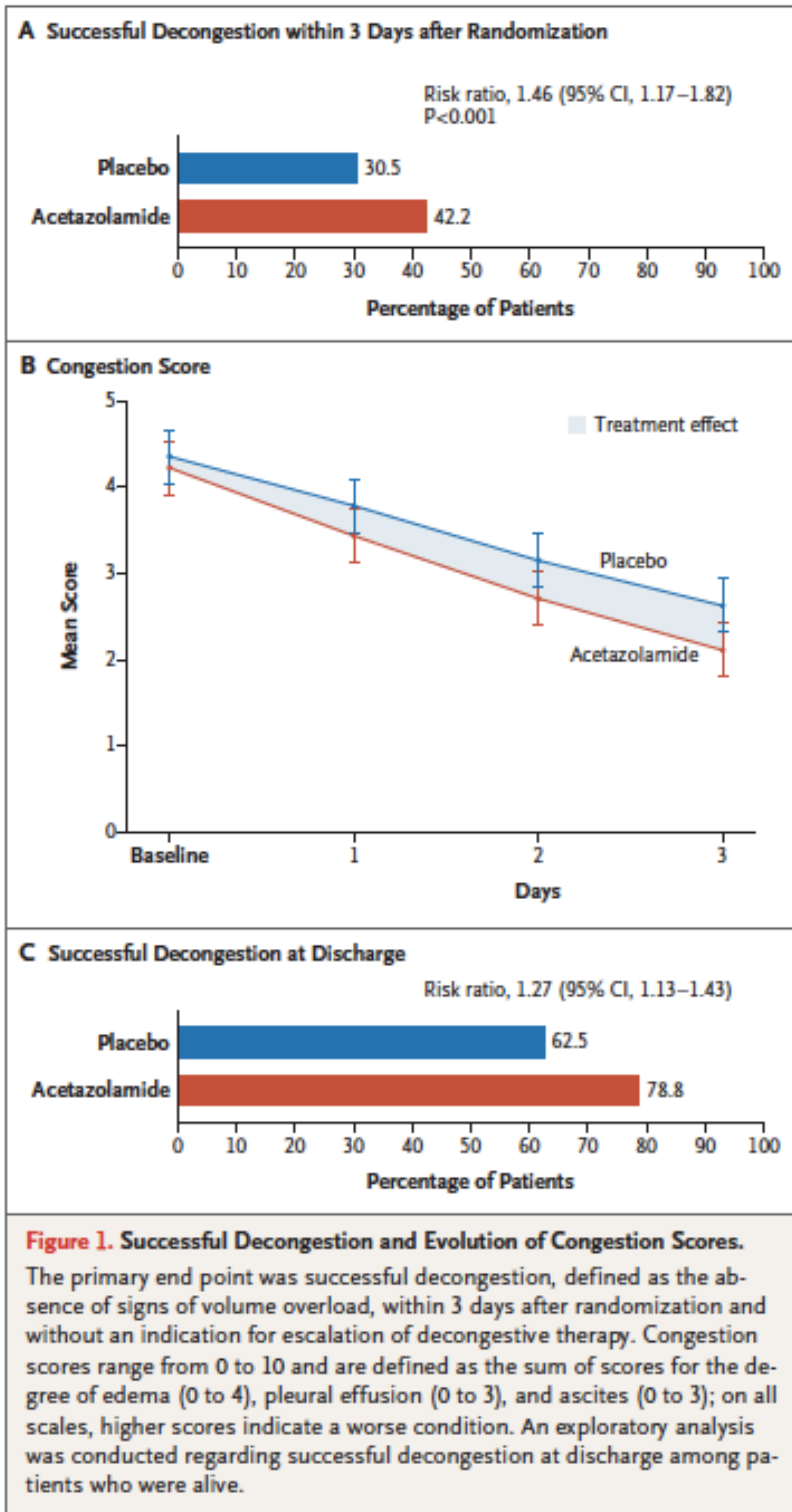


Figure 1. Successful Decongestion and Evolution of Congestion Scores.
The primary end point was successful decongestion, defined as the absence of signs of volume overload, within 3 days after randomization and without an indication for escalation of decongestive therapy. Congestion scores range from 0 to 10 and are defined as the sum of scores for the degree of edema (0 to 4), pleural effusion (0 to 3), and ascites (0 to 3); on all scales, higher scores indicate a worse condition. An exploratory analysis was conducted regarding successful decongestion at discharge among patients who were alive.

Déplétion efficace :
42,2 % VS 30,5%
= +46% amélioration

Hospitalisation :
8,8 VS 9,9 jours
= -1,1 jours

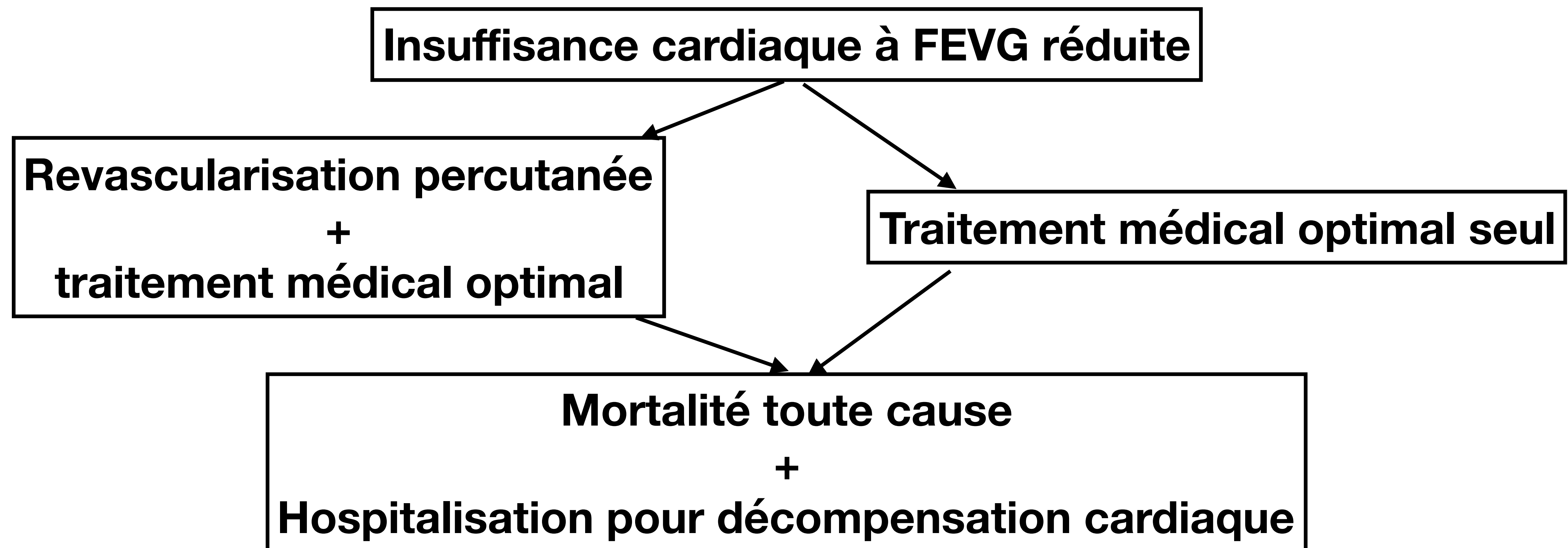
REVIVED-BCIS2

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Percutaneous Revascularization for Ischemic Left Ventricular Dysfunction

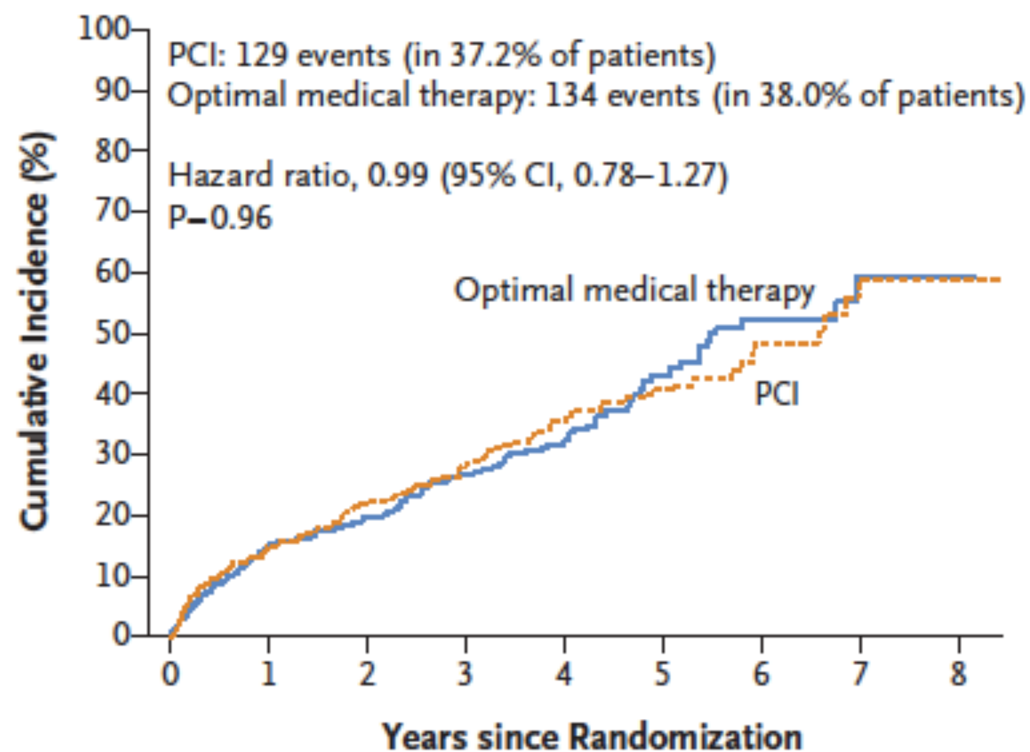
Divaka Perera, M.D., Tim Clayton, M.Sc., Peter D. O'Kane, M.D., John P. Greenwood, Ph.D., Roshan Weerackody, Ph.D., Matthew Ryan, Ph.D., Holly P. Morgan, M.B., B.Ch., Matthew Dodd, M.Sc., Richard Evans, B.A., Ruth Canter, M.Sc., Sophie Arnold, M.Sc., Lana J. Dixon, Ph.D., Richard J. Edwards, Ph.D., Kalpa De Silva, Ph.D., James C. Spratt, M.D., Dwayne Conway, M.D., James Cotton, M.D., Margaret McEntegart, Ph.D., Amedeo Chiribiri, Ph.D., Pedro Saramago, Ph.D., Anthony Gershlick, M.D., Ajay M. Shah, M.D., Andrew L. Clark, M.D., and Mark C. Petrie, M.D., for the REVIVED-BCIS2 Investigators*



REVIVED-BCIS2

- Revascularisation dans IC à FEVG réduite : IIaC
- STICH (2010) : bénéfice à 10 ans après pontage
- Inclusion : FEVG <35% + coronaropathie + viabilité (IRM ou écho stress)

REVIVED-BCIS2



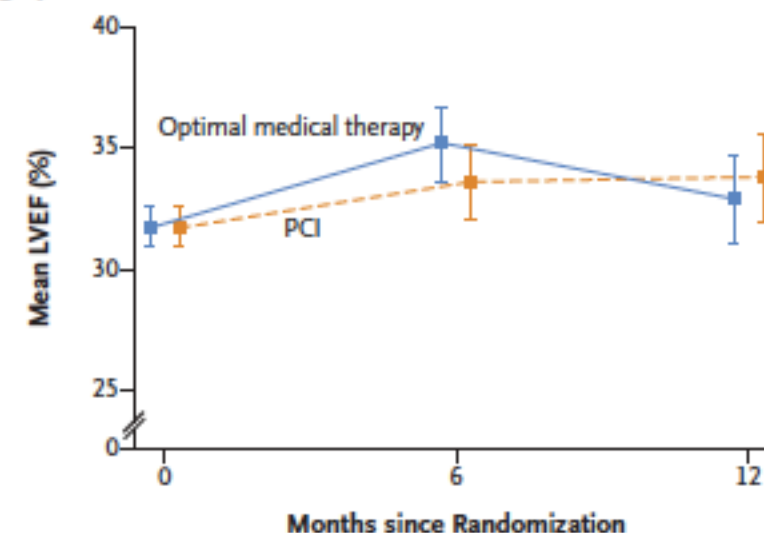
No. at Risk

PCI	347	295	262	179	130	80	32	14	3
Optimal medical therapy	353	299	276	191	142	82	33	10	1

Figure 1. Primary Outcome of Death from Any Cause or Hospitalization for Heart Failure.

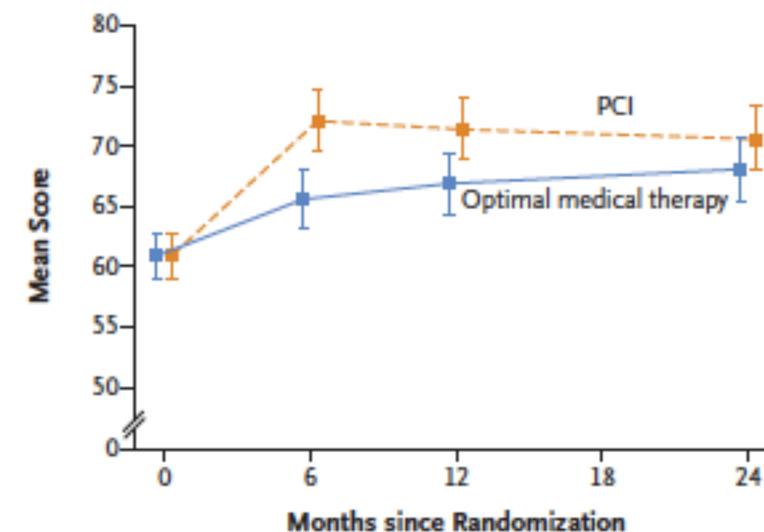
Shown are Kaplan–Meier estimates of the cumulative incidence of death from any cause or hospitalization for heart failure in a time-to-first-event analysis. The overall incidence is based on the total number of events in each group in the intention-to-treat population over the entire follow-up period. PCI denotes percutaneous coronary intervention.

Pas de bénéfice



No. of Patients

PCI	264	276	262
Optimal medical therapy	276	264	267



No. of Patients

PCI	319	270	268	228
Optimal medical therapy	318	285	268	228

Figure 3. Major Secondary Outcomes.

Panel A shows the echocardiographic estimates of the LVEF at baseline, 6 months, and 12 months, as quantified in a blinded fashion at the core laboratory. The LVEF was imputed as 0% for the patients who died. Panel B shows the Kansas City Cardiomyopathy Questionnaire (KCCQ) overall summary scores at baseline, 6 months, 12 months, and 24 months. The KCCQ overall summary score ranges from 0 to 100, with higher scores indicating better quality of life. In both panels, data are mean values derived from a linear mixed-effects model; I bars indicate 95% confidence intervals.

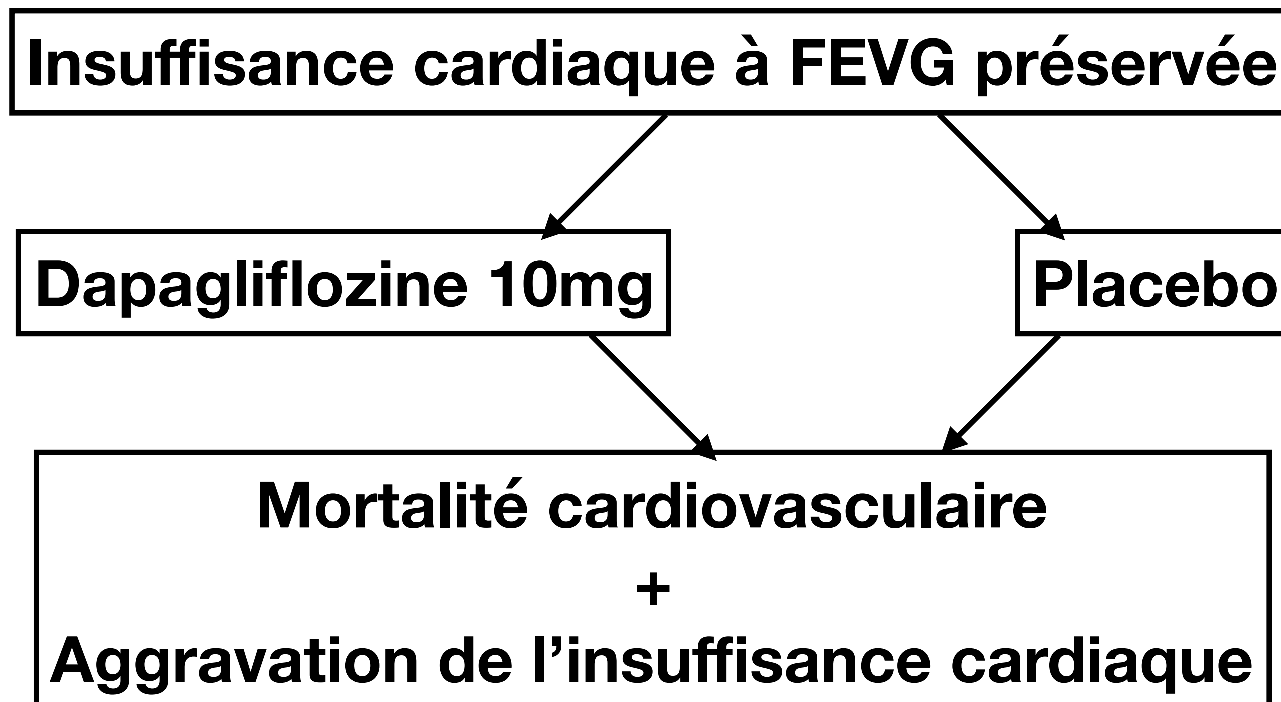
DELIVER

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Dapagliflozin in Heart Failure with Mildly Reduced or Preserved Ejection Fraction

S.D. Solomon, J.J.V. McMurray, B. Claggett, R.A. de Boer, D. DeMets, A.F. Hernandez, S.E. Inzucchi, M.N. Kosiborod, C.S.P. Lam, F. Martinez, S.J. Shah, A.S. Desai, P.S. Jhund, J. Belohlavek, C.-E. Chiang, C.J.W. Borleffs, J. Comin-Colet, D. Dobreanu, J. Drozdz, J.C. Fang, M.A. Alcocer-Gamba, W. Al Habeeb, Y. Han, J.W. Cabrera Honorio, S.P. Janssens, T. Katova, M. Kitakaze, B. Merkely, E. O'Meara, J.F.K. Saraiva, S.N. Tereshchenko, J. Thierer, M. Vaduganathan, O. Vardeny, S. Verma, V.N. Pham, U. Wilderäng, N. Zaozerska, E. Bachus, D. Lindholm, M. Petersson, and A.M. Langkilde, for the DELIVER Trial Committees and Investigators*

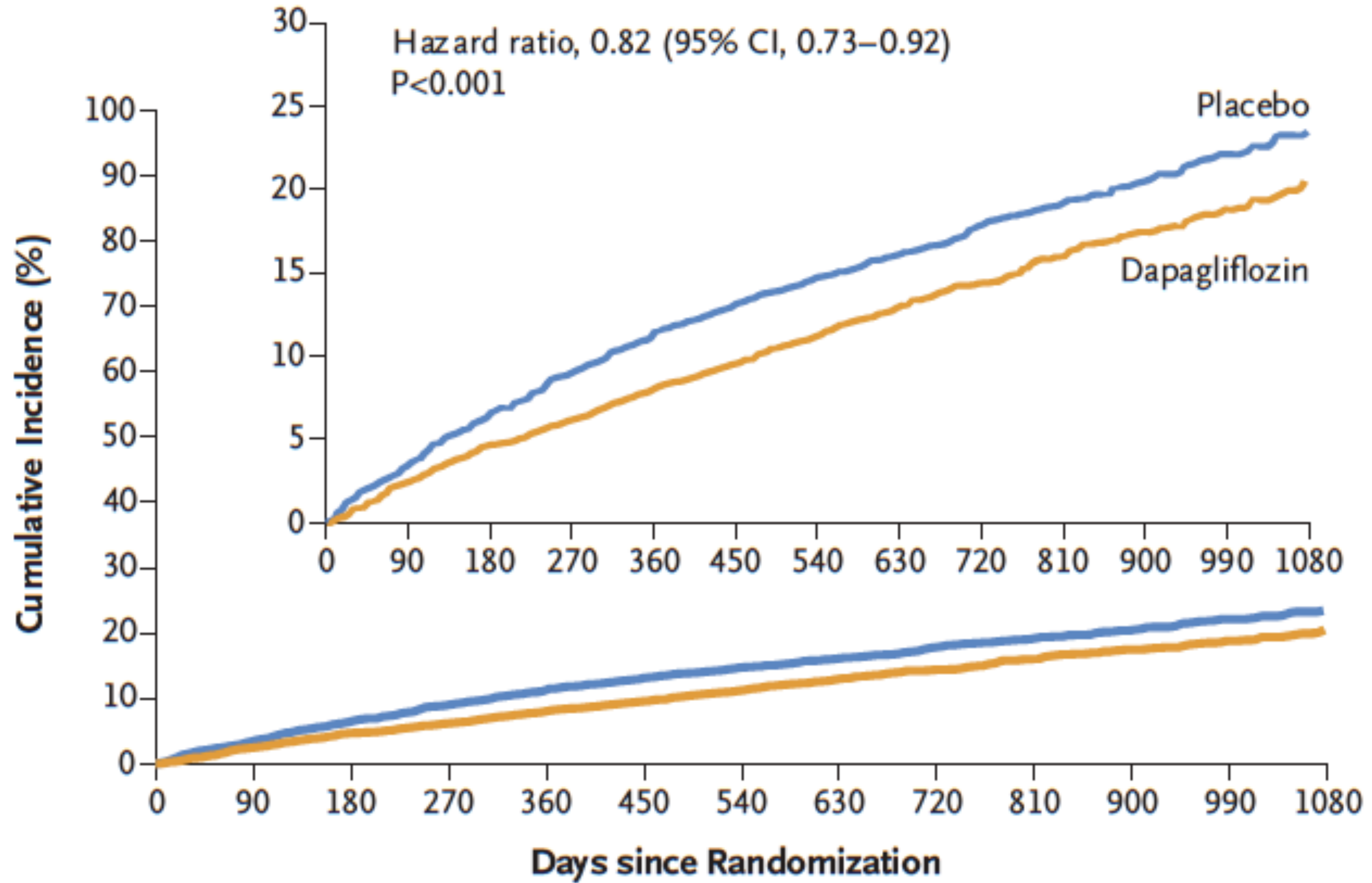


DELIVER

- Inhibiteurs de SGLT2 (cotransporteur de sodium et glucose dans le tubule proximal)
- DAPA-HF (2019) : efficacité de la dapagliflozine dans ICFEr
- EMPEROR-preserved : efficacité de l'empagliflozine dans ICFEp
- Inclusion : >40 ans + FEVG >40% + cardiopathie structurelle + élévation BNP/NTproBNP
- Ambulatoire ou hospitalisé

DELIVER

A Primary Outcome

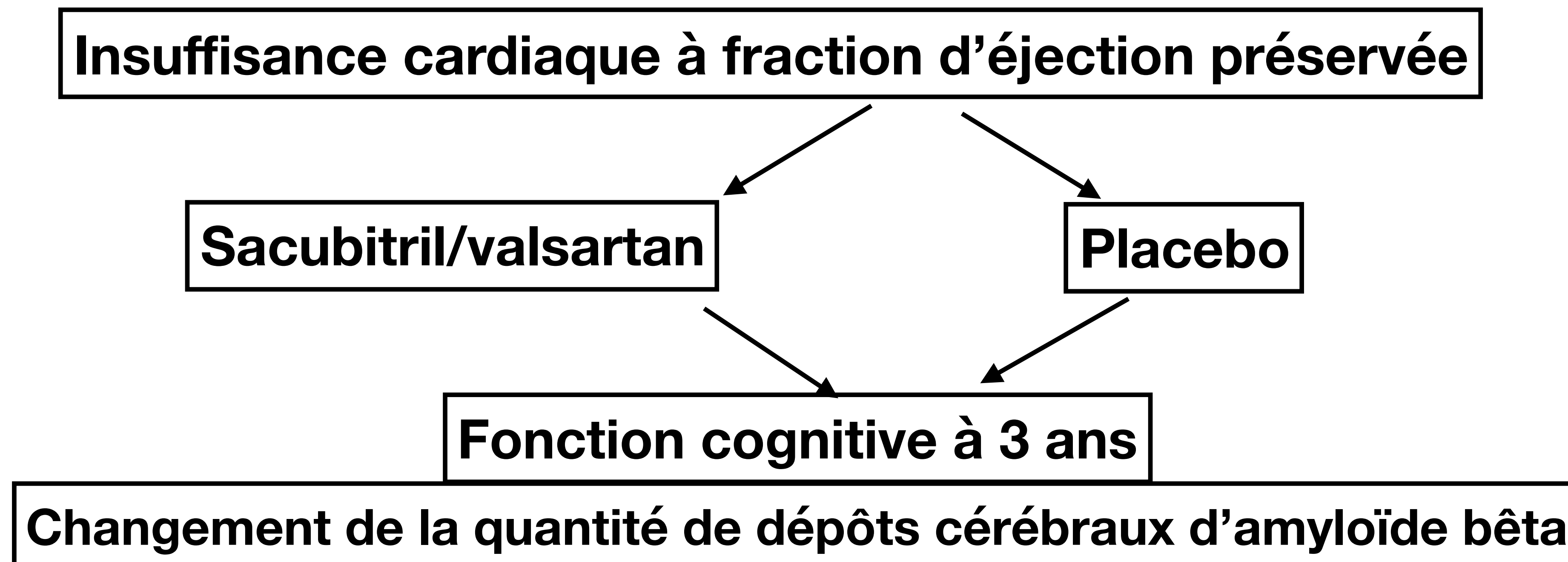


No. at Risk													
Placebo	3132	3007	2896	2799	2710	2608	2318	2080	1923	1554	1140	772	383
Dapagliflozin	3131	3040	2949	2885	2807	2716	2401	2147	1982	1603	1181	801	389

Mortalité CV + aggravation IC : -18%

PERSPECTIVE

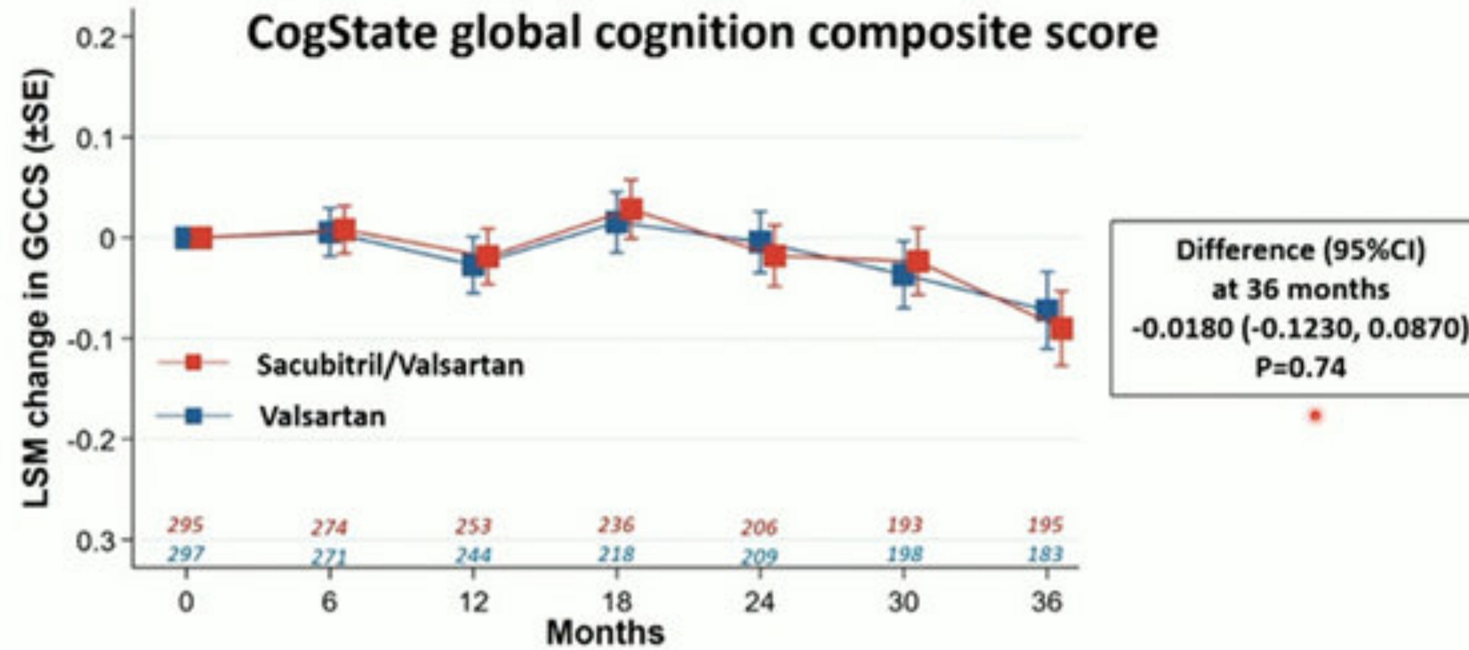
PERSPECTIVE : efficacité et sécurité du sacubitril/valsartan vs. valsartan seul sur la fonction cognitive chez les patients insuffisants cardiaques à FEVG préservée

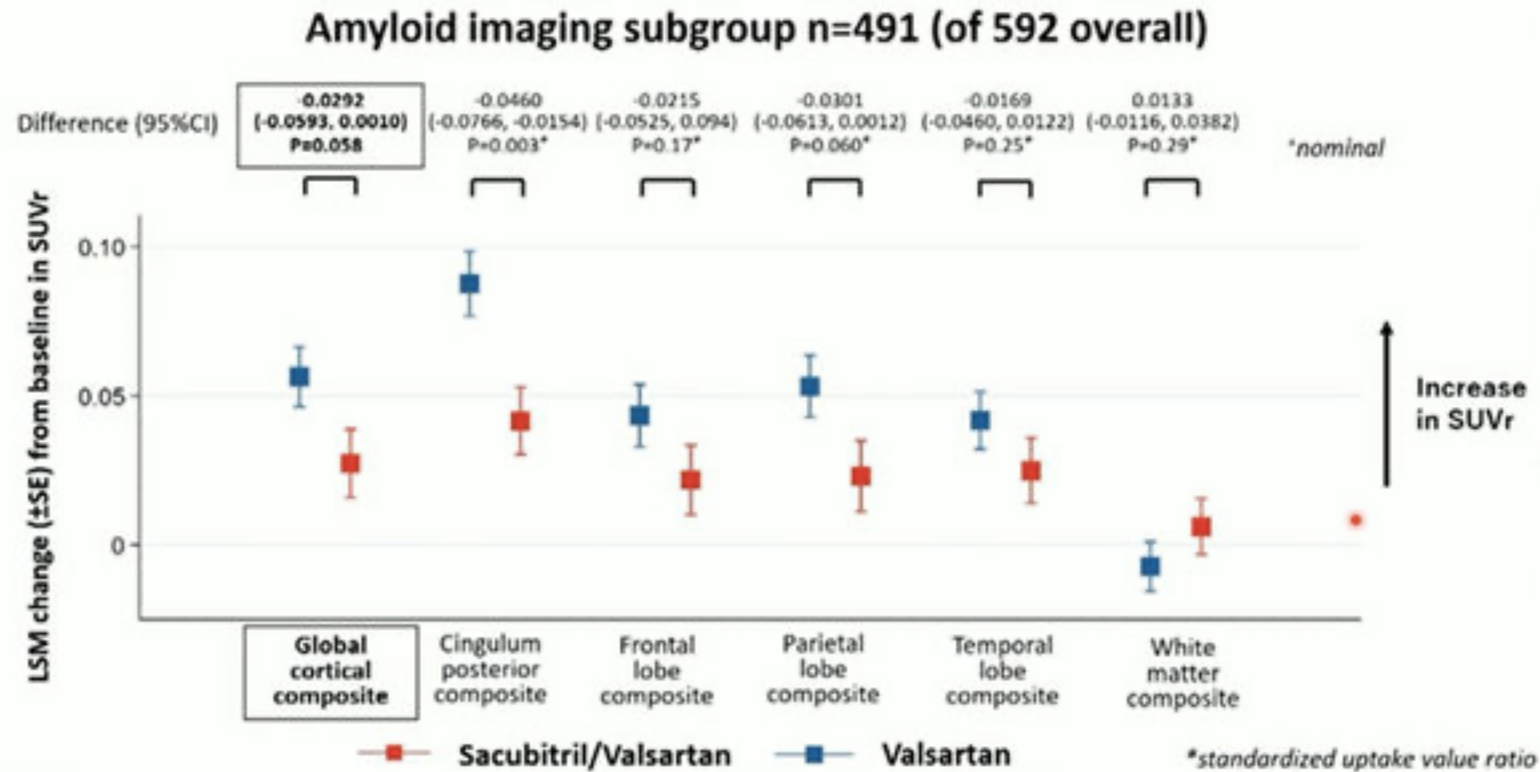


PERSPECTIVE

- Néprilysine : enzyme qui participe à la dégradation de l'amyloïde bêta
- Inhibition de la néprylisine => Alzheimer ?
- Inclusion : IC avec FEVG >40% + >60 ans + NTproBNP élevé et/ou hospitalisation pour décompensation cardiaque

PERSPECTIVE





Pas de différence

Take home message

Décompensation cardiaque : DOUBLE diurétique IV

Non, PAS D'ANGIOPLASTIE pour l'insuffisant cardiaque non angineux

Oui à la DAPAGLIFLOZINE pour l'ICFEp

Le sacubitril/ valsartan ne rend pas dément pendant 3 ans :)

Merci pour votre attention