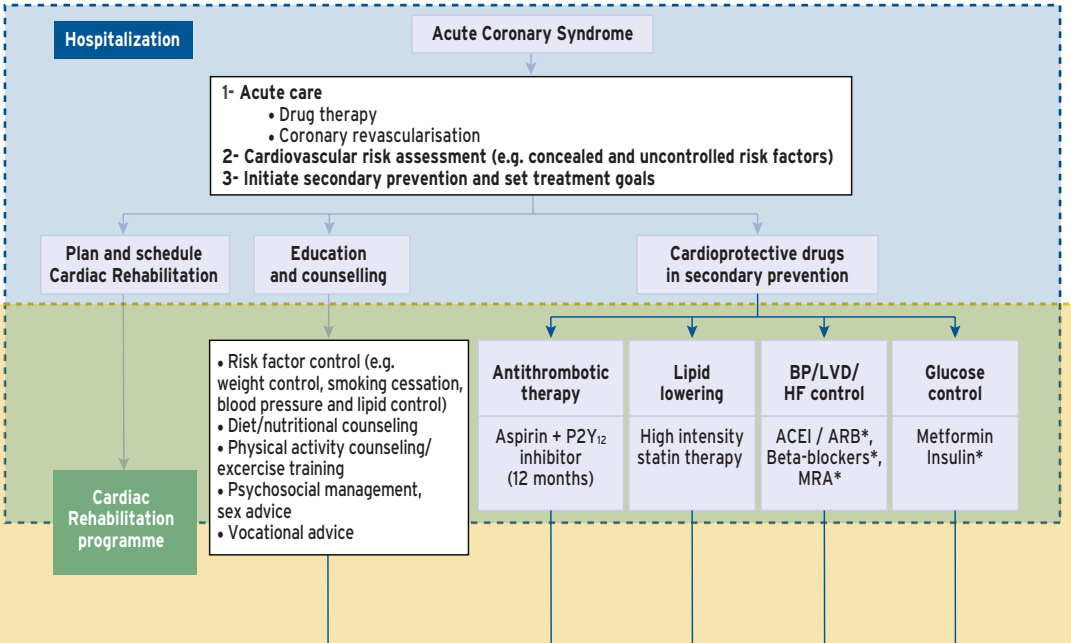
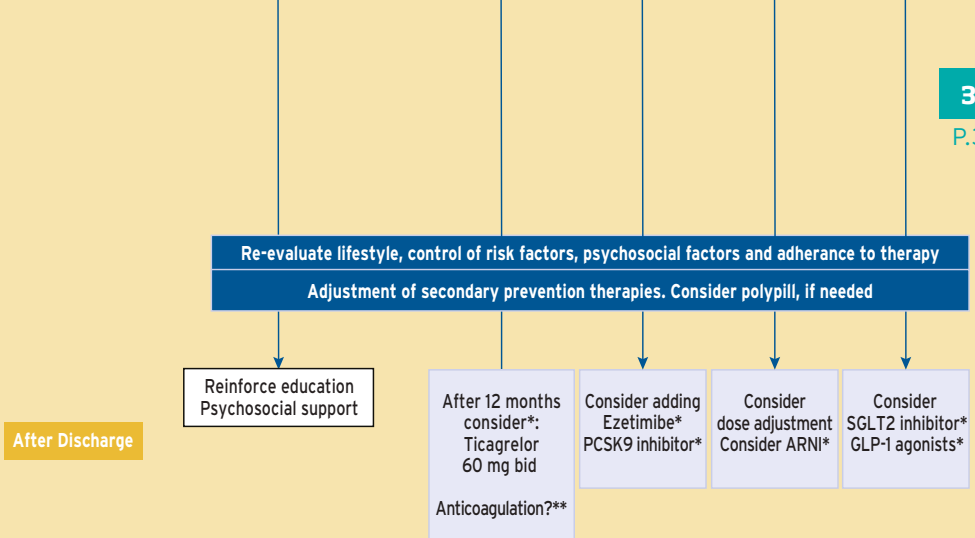
CHAPTER 3

SECONDARY PREVENTION AFTER ACS

SECONDARY PREVENTION STRATEGIES after ACS



3.1
P.39



*When individually indicated and without specific contraindications. - **Rivaroxaban 2.5 mg bid pending approval for indication in chronic CAD.

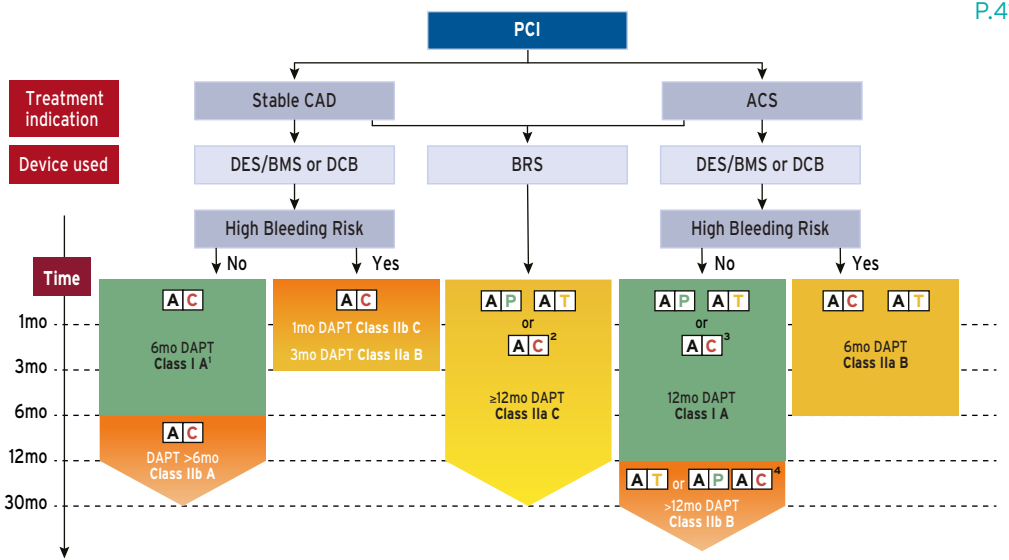
Reference modified from Cortés-Beringola A. Eur J Prev Cardiol 2017; 24(3 suppl): 22-28.

After ACS: POTENTIAL STRATEGIES TO OPTIMIZE SECONDARY PREVENTION THERAPY

Potential strategies to optimize secondary prevention therapy after ACS

- Participation in a comprehensive, multi-disciplinary cardiac rehabilitation programme after hospital discharge
- Coordination with primary care provider (and other specilaists) in therapeutic plan and objectives
- Re-check and reinforce advise on all lifestyle changes (diet, physical activity, smoking cessation...) during follow-up visits
- Check and optimise doses of all indicated secondary prevention drugs
- Use of specialist support, nicotine replacement therapies, varenicline, and/or bupropion individually or in combination for patients who do not quit or restart smoking
- Use of ezetimibe and/or a PCSK9 inhibitor in patients who remain at high risk with LDL-cholesterol >70 mg/dl despite apropriate diet and maximally tolerated doses of statins
- Use of a polypill or combination therapy in patients with suboptimal adherence to drug therapy

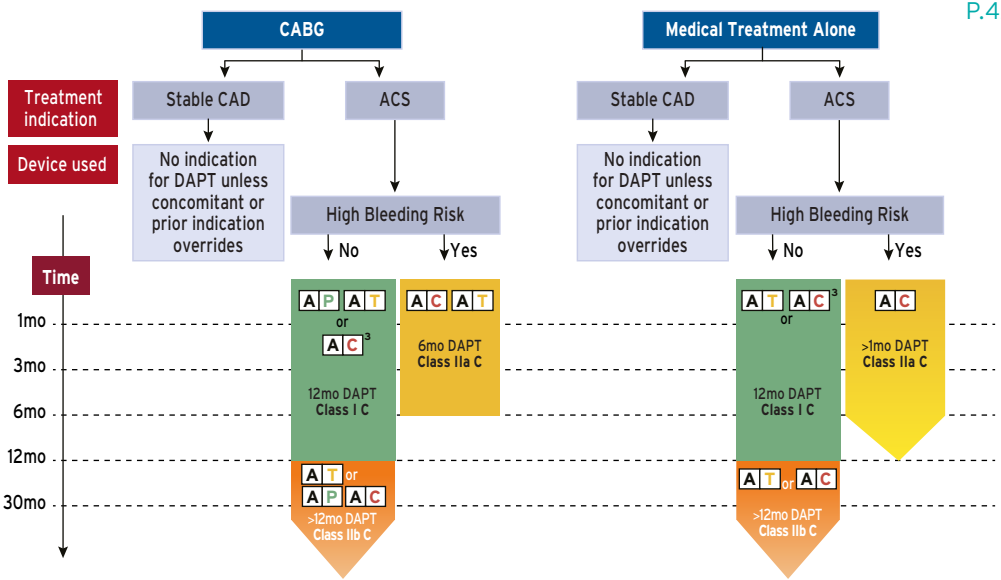
ANTITHROMBOTIC TREATMENT: Dual antiplatelet therapy duration in patients with ACS (1)



Reference: Valgimigli M, et al. Eur Heart J. 2018; 39:213-260.

A = Aspirin C = Clopidogrel P = Prasugrel T = Tricagrelor

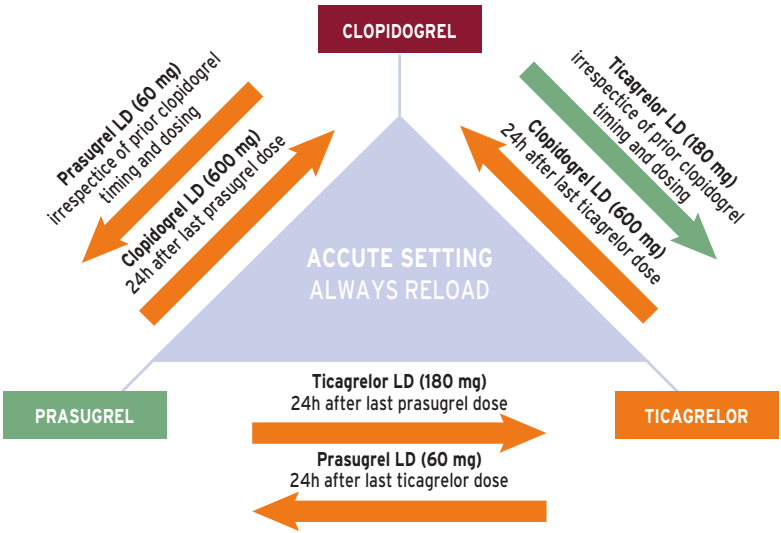
ANTITHROMBOTIC TREATMENT: Dual antiplatelet therapy duration in patients with ACS (2)



Reference: Valgimigli M, et al. Eur Heart J. 2018; 39:213-260.

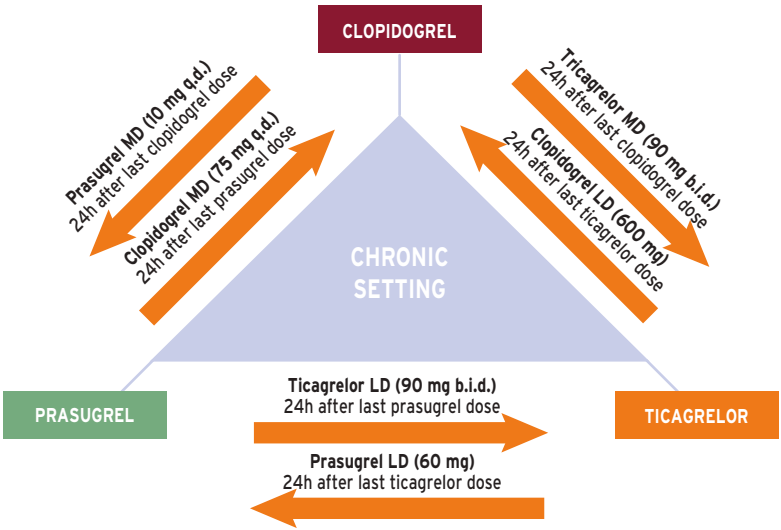
A = Aspirin C = Clopidogrel P = Prasugrel T = Tricagrelor

ANTITHROMBOTIC TREATMENT: Switching between $P2Y_{12}$ inhibitors for DAPT after ACS (1)



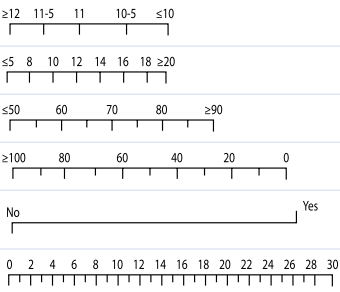
Reference: Valgimigli M, et al. Eur Heart J. 2018;39:213-260.

ANTITHROMBOTIC TREATMENT: Switching between P2Y12 inhibitors for DAPT after ACS (2)

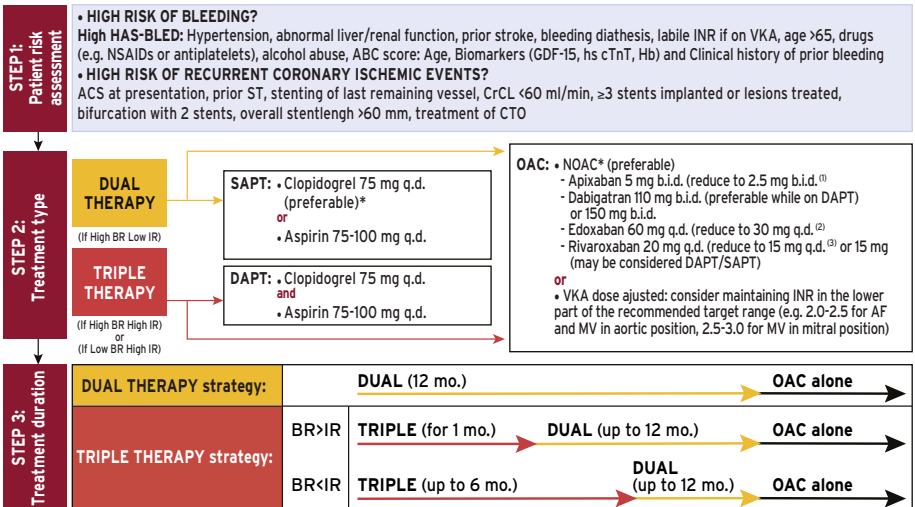


Reference: Valgimigli M, et al. Eur Heart J. 2018;39:213-260.

ANTITHROMBOTIC TREATMENT:
Risk scores validated for DAPT duration decision-making

	PRECISE-DAPT score	DAPT score
Time of use	At the time of coronary stenting	After 12 months of uneventful DAPT
DAPT duration strategies assessed	Short DAPT (3-6 months) **vs.** Standard/long DAPT (12-24 monts)	Standard DAPT (12 months) **vs.** Long DAPT (30 months)
Score calculation		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
Score range	0 to 100 points	−2 to 10 points
Decision making cut-off	Score ≥25 → Short DAPT Score <25 → Standard/long DAPT	Score ≥2 → Long DAPT Score <2 → Standard DAPT
Electronic calculator	www.precisedaptscore.com	www.daptstudy.org

ANTITHROMBOTIC TREATMENT in patients with concomitant indication for DAPT and chronic oral anticoagulation (1)

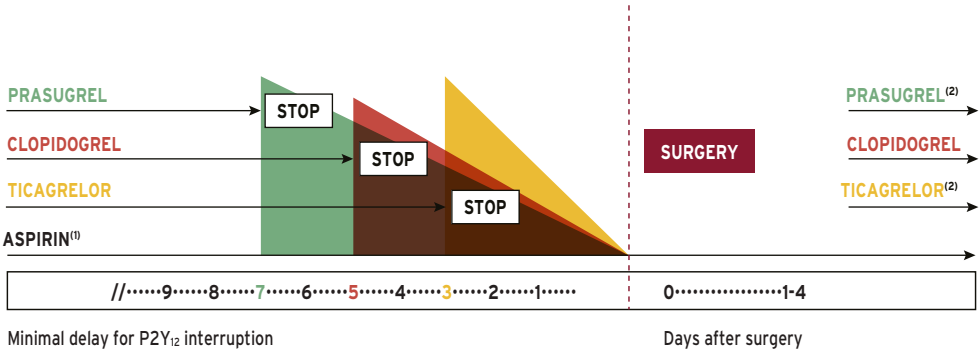


* In case of selecting dual therapy immediately after stent implantation clopidogrel should be selected as single antiplatelet agent. Aspirin should however be administered at the time of the intervention.

(1) Age ≥80 years, body weight ≤60 kg or serum creatinine level ≥1.5 mg/dL.
(2) CrCl of 30-50 ml/min, body weight ≤60 kg, concomitant use of verapamil, quinidine or dronedarone.
(3) CrCl 30-49 ml/min.

Reference adapted from Valgimigli M et al. Eur Heart J. 2018;39:213-260.

ANTITHROMBOTIC TREATMENT: Management of DAPT after ACS in patients with indication for surgery



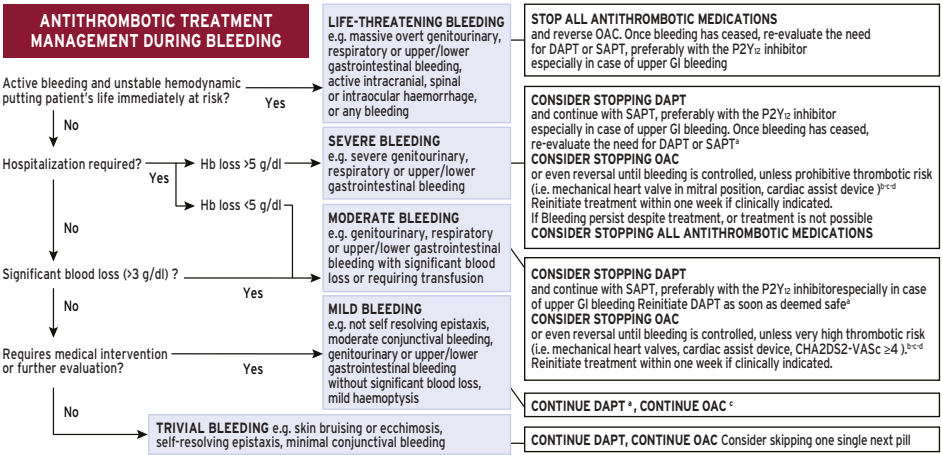
= Expected average platelet function recovery

(1) Decision to stop aspirin throughout surgery should be made on a single case basis taking into account the surgical bleeding risk

(2) In patients not requiring OAC

Reference: Valgimigli et al. Eur Heart J.2018; 39:213-260.

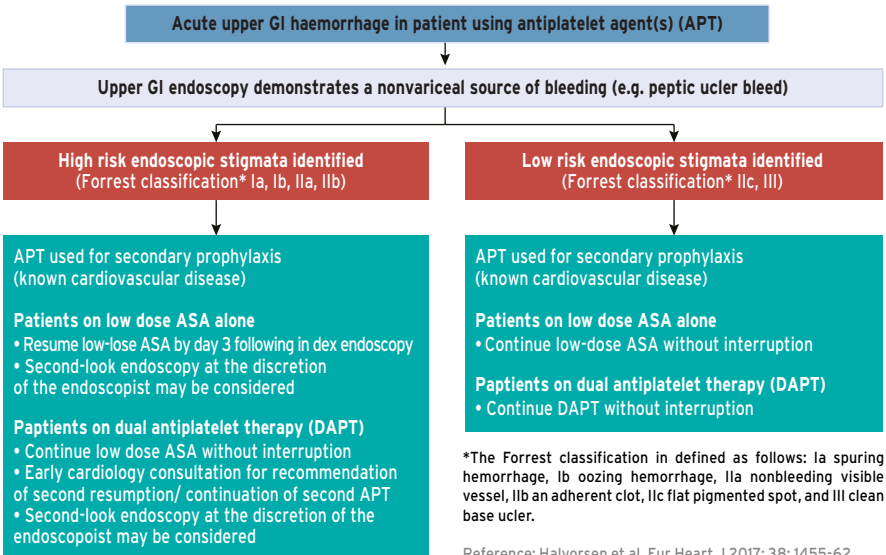
ANTITHROMBOTIC TREATMENT: Management of acute bleeding after ACS



[a] Consider shortening DAPT duration or switching to less potent P2Y12 inhibitor (i.e. from ticagrelor/prasugrel to clopidogrel), especially if recurrent bleeding occurs [b] Reinitiate treatment within one week if clinically indicated. For Vitamin-K antagonist consider a target INR of 2.0-2.5 unless overriding indication (i.e. mechanical heart valves or cardiac assist device) for NOAC consider the lowest effective dose. - [c] In case of triple therapy consider downgrading to dual therapy, preferably with clopidogrel and OAC. - [d] If patients on dual therapy, consider stopping antiplatelet therapy if deemed safe.

Reference: Valgimigli et al. Eur Heart J.2018; 39:213-260.

ANTITHROMBOTIC TREATMENT: Management of antiplatelet therapy after acute GI bleeding



*The Forrest classification in defined as follows: Ia spuring hemorrhage, Ib oozing hemorrhage, IIa nonbleeding visible vessel, IIb an adherent clot, IIc flat pigmented spot, and III clean base ucler.

Reference: Halvorsen et al. Eur Heart J 2017; 38: 1455-62.

The ACCA Clinical Decision Making Toolkit is produced by the **Acute Cardiovascular Care Association (ACCA)**, developed and distributed through an educational grant from AstraZeneca. AstraZeneca was not involved in the development of this publication and in no way influenced its content.