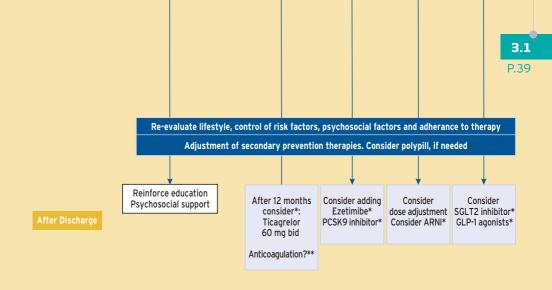


SECONDARY PREVENTION AFTER ACS

3.1	GENERAL SECONDARY PREVENTION STRATEGIES		
	AND LIPID LOWERING	p.38	
	H. Bueno, S. Halvorsen		
3.2	ANTITHROMBOTIC TREATMENT	p.4	
	E Cooks C Holyayaan		

SECONDARY PREVENTION STRATEGIES after ACS

P.38 Acute Coronary Syndrome Hospitalization 1- Acute care Drug therapy · Coronary revascularisation 2- Cardiovascular risk assessment (e.g. concealed and uncontrolled risk factors) 3- Initiate secondary prevention and set treatment goals Plan and schedule Education Cardioprotective drugs Cardiac Rehabilitation and counselling in secondary prevention • Risk factor control (e.g. Antithrombotic Lipid BP/LVD/ Glucose weight control, smoking cessation, lowering HF control control therapy blood pressure and lipid control) Diet/nutritional counseling Aspirin + P2Y₁₂ High intensity ACEI / ARB*. Metformin Physical activity counseling/ Insulin* inhibitor statin therapy Beta-blockers*. excercise training (12 months) MRA* Psychosocial management, Cardiac sex advice Rehabilitation Vocational advice programme



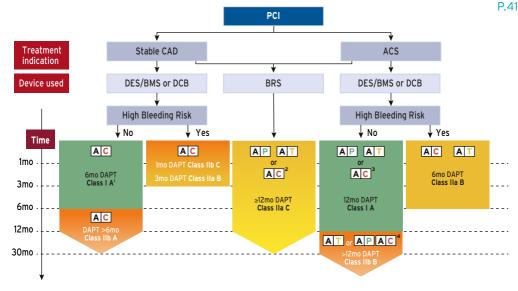
^{*}When individually indicated and without specific contraindications. - **Rivaroxaban 2.5 mg bid pending approval for indication in chronic CAD.

After ACS: POTENTIAL STRATEGIES TO OPTIMIZE SECONDARY PREVENTION THERAPY

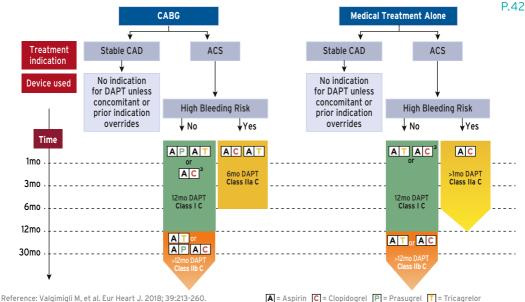
Potential strategies to optimize secondary prevention therapy after ACS

- 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

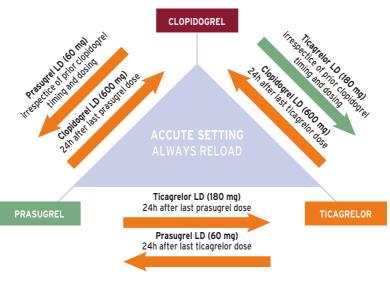
ANTITHROMBOTIC TREATMENT: Dual antiplatelet therapy duration in patients with ACS (1)



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

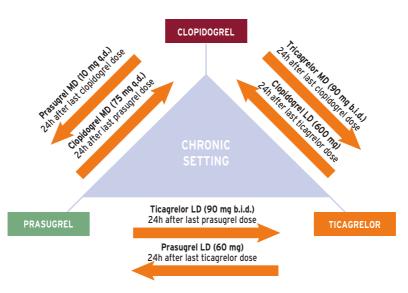


ANTITHROMBOTIC TREATMENT: Switching between P2Y₁₂ inhibitors for DAPT after ACS (1)



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

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



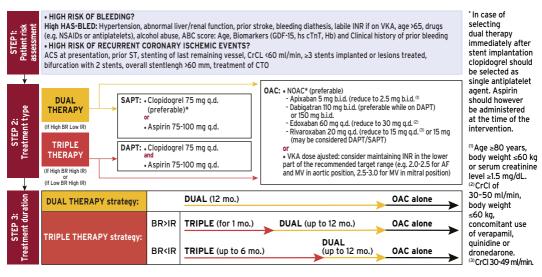
Reference: Valgimigli M, et al. Eur Heart J. 2018;39:213-260.

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

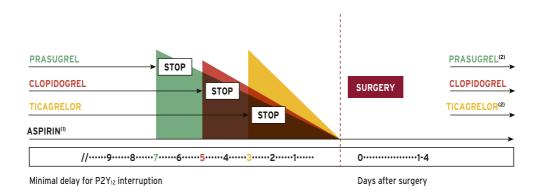
	PRECISE-DAPT score	DAPT score	
Time of use	At the time of coronary stenting	After 12 months of uneventful DAPT	
DAPT duration Short DAPT (3-6 months) strategies assessed vs. Standard/long DAPT (12-24 monts)		Standard DAPT (12 months) vs. Long DAPT (30 months)	
Score calculation	HB	Age ≥75 65 to <75	
Score range	0 to 100 points	−2 to 10 points	
Decision making cut-off Score ≥25 \rightarrow Short DAPT score <25 \rightarrow 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)

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



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

ANTITHROMBOTIC TREATMENT: Management of acute bleeding after ACS

ANTITHROMBOTIC TREATMENT STOP ALL ANTITHROMBOTIC MEDICATIONS LIFE-THREATENING BLEEDING and reverse OAC. Once bleeding has ceased, re-evaluate the need MANAGEMENT DURING BLEEDING e.g. massive overt genitourinary. for DAPT or SAPT, preferably with the P2Y12 inhibitor respiratory or upper/lower especially in case of upper GI bleeding gastrointestinal bleeding. Active bleeding and unstable hemodynamic active intracranial, spinal putting patient's life immediately at risk? or intraocular haemorrhage. CONSIDER STOPPING DAPT Yes or any bleeding and continue with SAPT, preferably with the P2Y12 inhibitor Nο especially in case of upper GI bleeding. Once bleeding has ceased, SEVERE BLEEDING re-evaluate the need for DAPT or SAPT^a e.g. severe genitourinary. CONSIDER STOPPING OAC Hospitalization required? -→ Hb loss >5 a/dl respiratory or upper/lower or even reversal until bleeding is controlled, unless prohibitive thrombotic risk gastrointestinal bleeding (i.e. mechanical heart valve in mitral position, cardiac assist device)bod Reinitiate treatment within one week if clinically indicated. ➤ Hb loss <5 a/dl -</p> MODERATE BLEEDING If Bleeding persist despite treatment, or treatment is not possible Nο CONSIDER STOPPING ALL ANTITHROMBOTIC MEDICATIONS e.g. genitourinary, respiratory or upper/lower gastrointestinal bleeding with significant blood Significant blood loss (>3 g/dl) ? CONSIDER STOPPING DAPT loss or requiring transfusion and continue with SAPT, preferably with the P2Y₁₂ inhibitorespecially in case Yes of upper GI bleeding Reinitiate DAPT as soon as deemed safe^a Nο MILD BLEEDING CONSIDER STOPPING OAC e.g. not self resolving epistaxis. or even reversal until bleeding is controlled, unless very high thrombotic risk moderate conjunctival bleeding. (i.e. mechanical heart valves, cardiac assist device, CHA2DS2-VASc >4), brd Requires medical intervention genitourinary or upper/lower Reinitiate treatment within one week if clinically indicated. or further evaluation? Yes gastrointestinal bleeding

a Consider shortening DAPT duration or switching to less potent P2Y12 inhibitor (i.e. from ticagrelor/prasugrel to clopidogrel), especially if recurrent bleeding occurs Preinitiate 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, - In case of triple therapy consider downgrading to dual therapy, preferably with clopidogrel and OAC. - dlf patients on dual therapy, consider stopping antiplatelet therapy if deemed safe.

CONTINUE DAPT®, CONTINUE OAC®

CONTINUE DAPT, CONTINUE OAC Consider skipping one single next pill

without significant blood loss. mild haemoptysis

TRIVIAL BLEEDING e.g. skin bruising or ecchimosis.

self-resolving epistaxis, minimal conjunctival bleeding

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

No

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ANTITHROMBOTIC TREATMENT: Management of antiplatelet therapy after acute GI bleeding

Acute upper GI haemorrhage in patient using antiplatelet agent(s) (APT) Upper GI endoscopy demonstrates a nonvariceal source of bleeding (e.g. peptic ucler bleed) High risk endoscopic stigmata identified Low risk endoscopic stigmata identified (Forrest classification* la, lb, lla, llb) (Forrest classification* IIc, III) APT used for secondary prophylaxis APT used for secondary prophylaxis (known cardiovascular disease) (known cardiovascular disease) Patients on low dose ASA alone Patients on low dose ASA alone • Resume low-lose ASA by day 3 following in dex endoscopy Continue low-dose ASA without interruption Second-look endoscopy at the discretion Paptients on dual antiplatelet therapy (DAPT) of the endoscopist may be considered Continue DAPT without interruption Paptients on dual antiplatelet therapy (DAPT) Continue low dose ASA without interruption *The Forrest classification in defined as follows: la spuring Early cardiology consultation for recommendation hemorrhage, Ib oozing hemorrhage, Ila nonbleeding visible of second resumption/ continuation of second APT vessel. IIb an adherent clot. IIc flat pigmented spot, and III clean

hase ucler.

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

Second-look endoscopy at the discretion of the

endoscopoist may be considered

The ACCA Clinical Decision Making

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