



Con il Patrocinio di



Caso clinico 3:

Paziente con vasculopatia periferica e storia di PCI

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**Malattia coronarica cronica
in paziente già sottoposto a PCI:
dallo studio Compass alla pratica clinica**

Strategie vincenti nella gestione
della terapia antitrombotica nel paziente
con cardiopatia ischemica cronica

Anamnesi

- Uomo, 64 anni
- Iperteso, diabetico, ex-fumatore
- Ater. TSA subcritica: **CID: 60%; CIS 45%**
- **Progresso STEMI** inferiore trattato con PTCA primria su coronaria dx (2 anni fa)
- **Claudicatio intermittens** di polpaccio sin. (IML < 50 metri; recente riduzione IML; Rutherford I° , categoria 3)



Eco-colo-doppler AI

Asse sin.:

- Fem. com.** flusso presente, discretamente modulato
- Fem. sup.** **occlusione prossimale**
- Poplitea** segnale doppler demodulato
- Tibiale ant.** flusso presente; pedidia presente al repere
- Tibiale post.** segnale doppler non registrabile

ABI alla pedidia = 0,61



Malattia coronarica cronica in paziente già sottoposto a PCI: dallo studio Compass alla pratica clinica



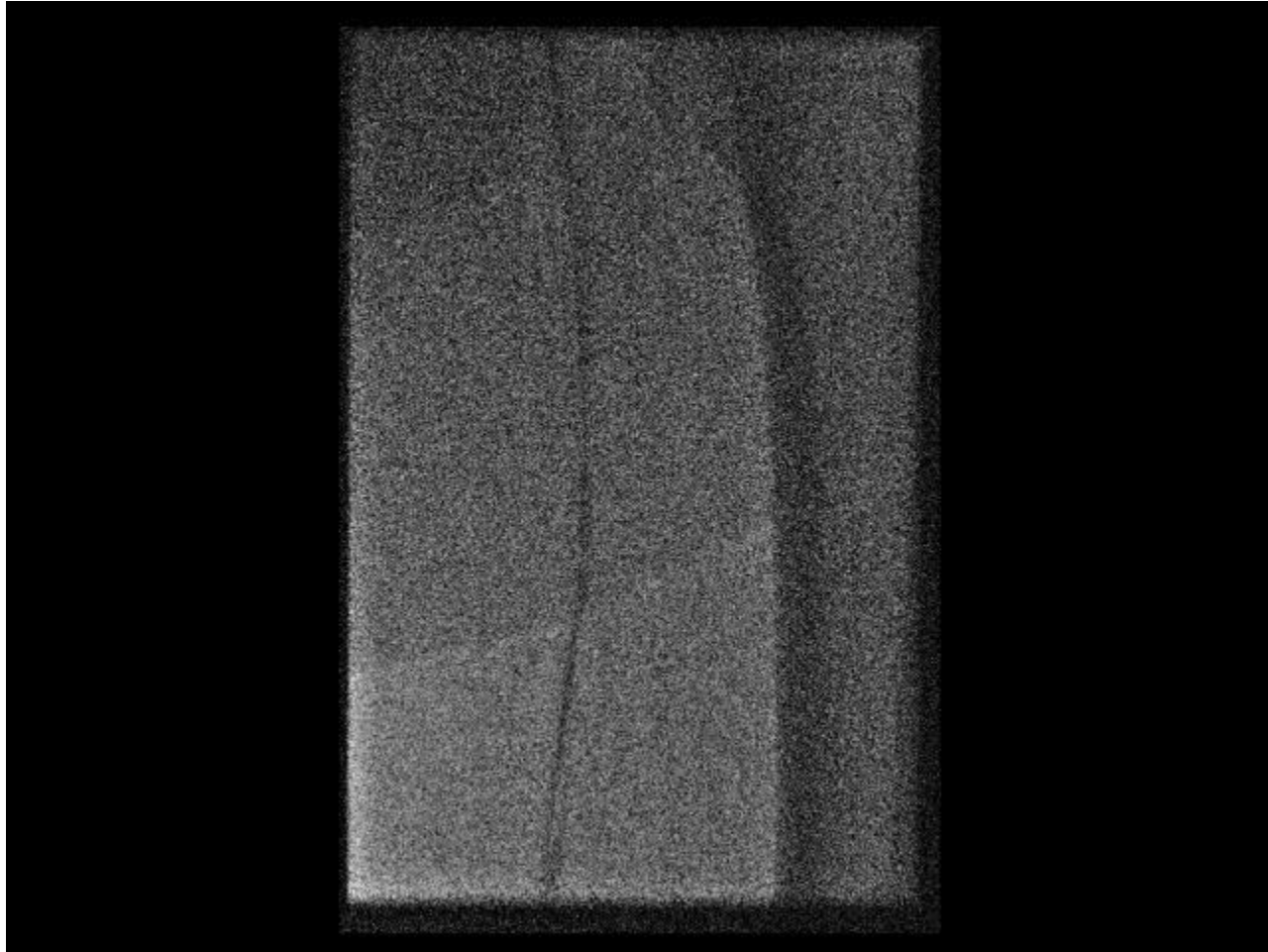
Malattia coronarica cronica in paziente già sottoposto a PCI: dallo studio Compass alla pratica clinica



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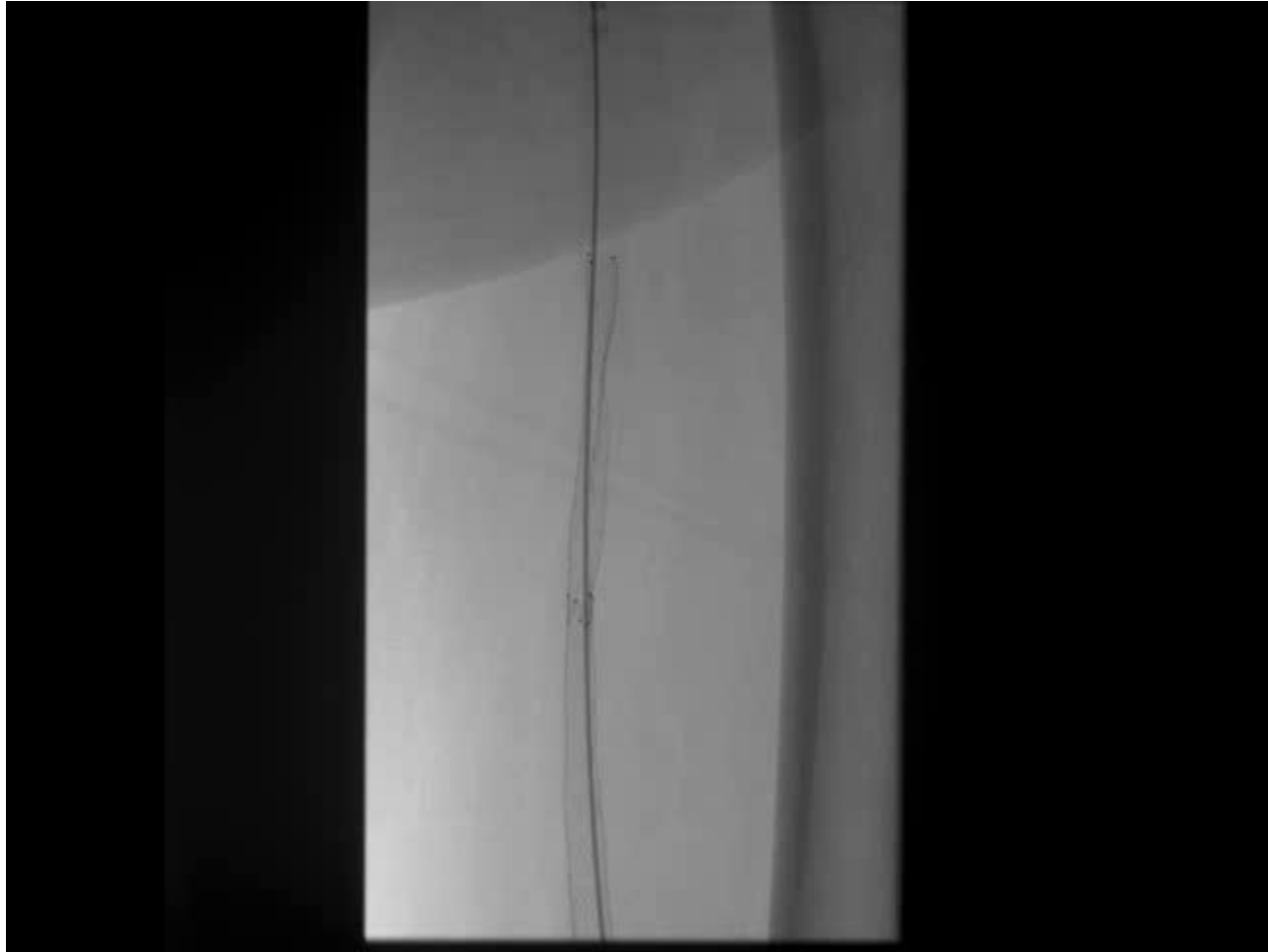
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Terapia alla dimissione

- Pantoprazolo 20 mg
- Acido acetil-salicilico 100 mg
- Clopidogrel 75 mg
- Atorvastatina 20 mg
- Ramipril 5 mg



Dopo 1 mese cosa fare ???

- Continuare con SAPT / DAPT ???
- Associare / sostituire con un anticoagulante ???
- Per quanto tempo ???



Current Vascular Protection Strategies Aim to Reduce Risk of Atherothrombotic CV and Limb Events in Patients with PAD

Vascular protection¹⁻⁴

Control of cardiovascular risk factors to limit atherosclerosis progression and stabilize existing plaques

Prevention of blood clot formation over any ruptured/eroded atherosclerotic plaques

Lifestyle changes

- Smoking cessation
- Regular exercise
- Healthy diet
- Weight management
- Psychosocial support

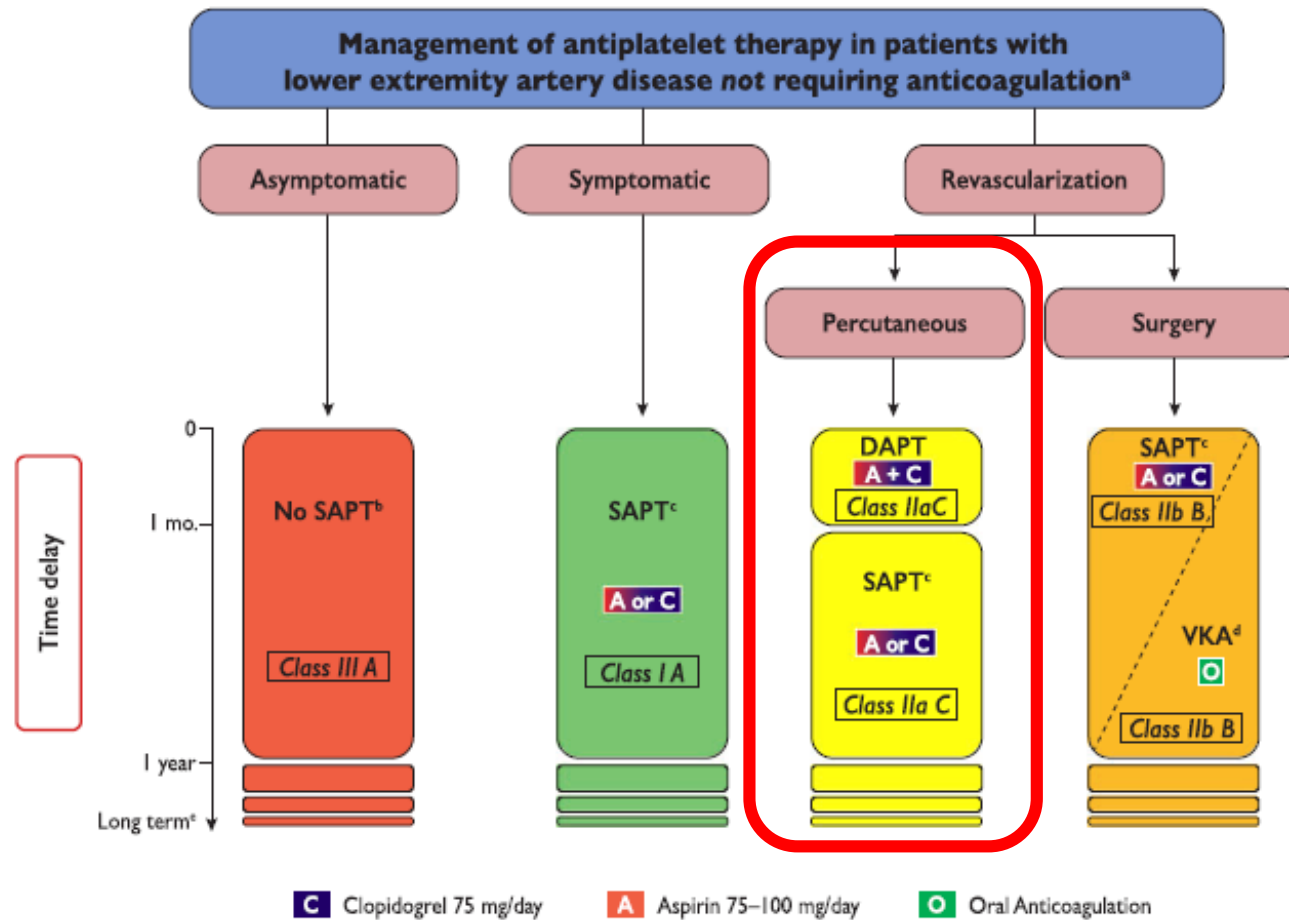
Medical therapies

- Lipid control – statins
- Hypertension control – ACE inhibitors/ARBs
- Diabetes control – insulin/anti-glycaemic drugs

Antithrombotic therapy



Antithrombotic therapy in LEAD



Antithrombotic therapies are indicated in patients with symptomatic LEAD. There proven benefit for their use in asymptomatic patients.



L.G. terapia post-rivascolarizzazione

- ACC/AHA e ESC sono divergenti
- Le raccomandazioni sono modulate dalle L.G. CAD, o dall'opinione di esperti
- ACCP: raccomandano DAPT **ante** post-PTA
- ESC: DAPT per almeno 1 mese post-PTA
- Gli anticoagulanti pos-PTA sono stati valutati in almeno tre trial: nessuno ha dimostrato un miglioramento significativo sulla pervietà

SAPT
dopo
1 mese

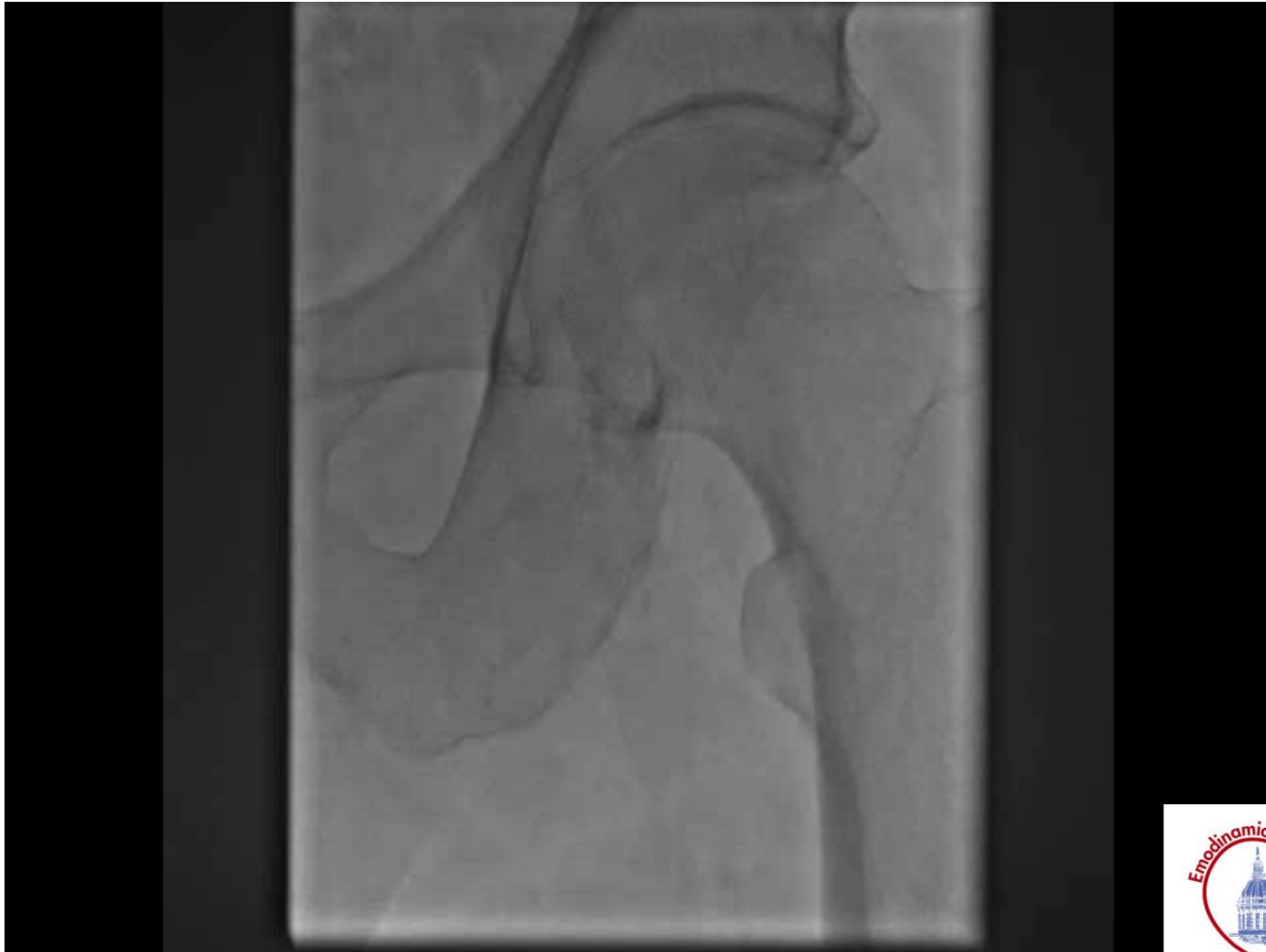


Sei mesi dopo...

- Ricomparsa di claudicatio al polpaccio di sinistra
- Eco-color-doppler AI:
sospetta **ristenosi intrastent**; stenosi critiche a valle, nel tratto medio-distale



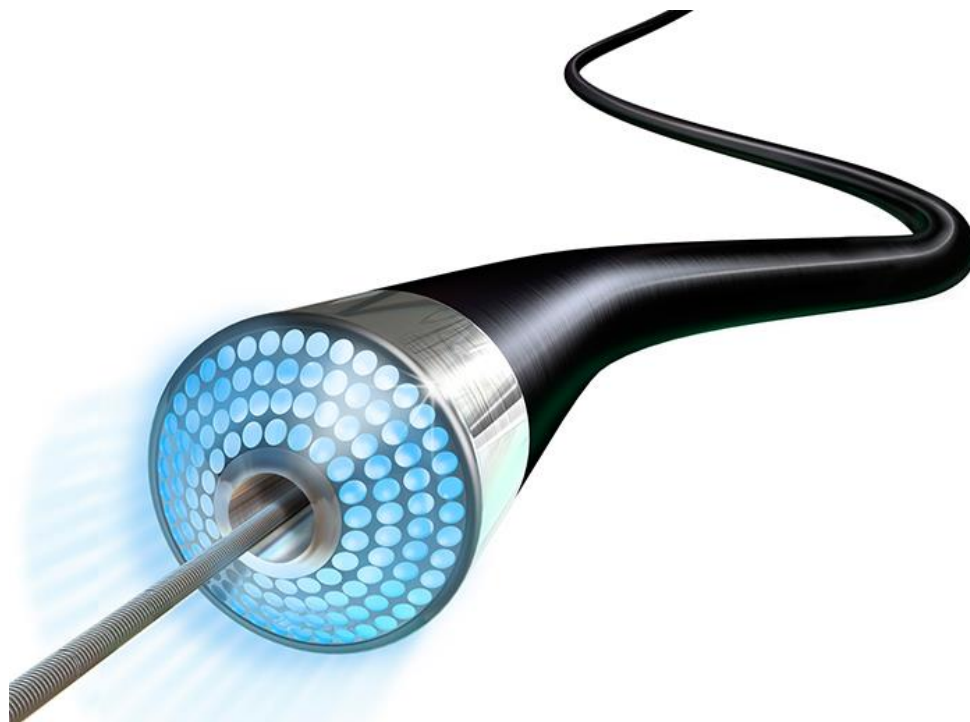
SFA Sin.



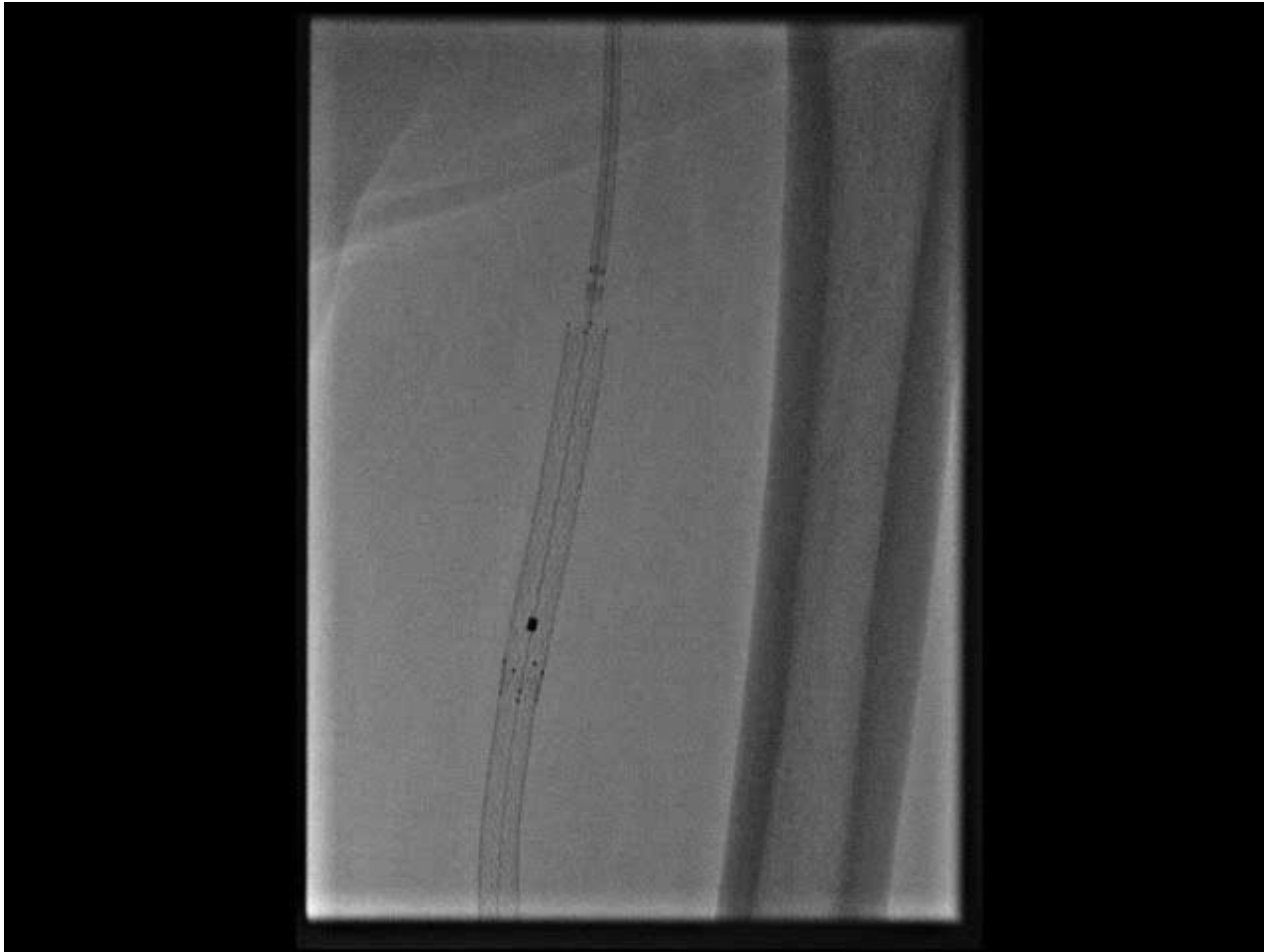
Laser Atherectomy

(Turbo-Elite - Spectranetics)

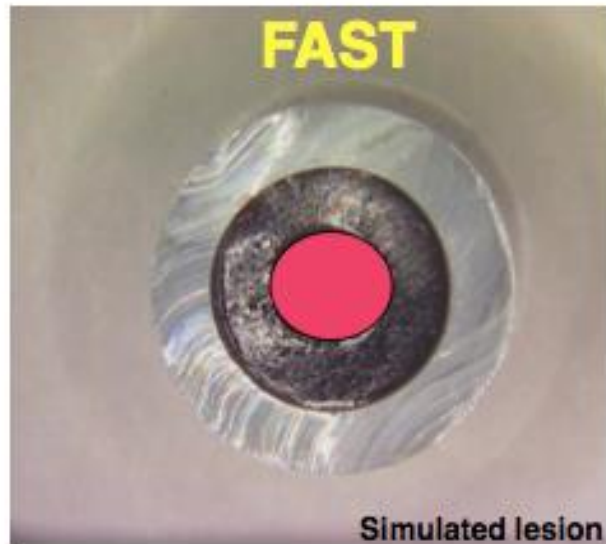

Turbo-Elite™
Laser Atherectomy Catheter



“Laser Atherectomy”

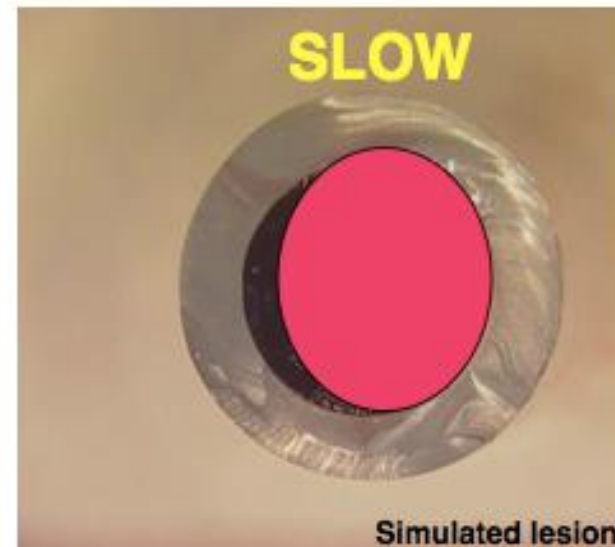


Slow Advancement is KEY!



Lumen diameter with
FAST ADVANCEMENT
(greater than 1 mm per
second).

2.3 Turbo Elite in 6mm tube

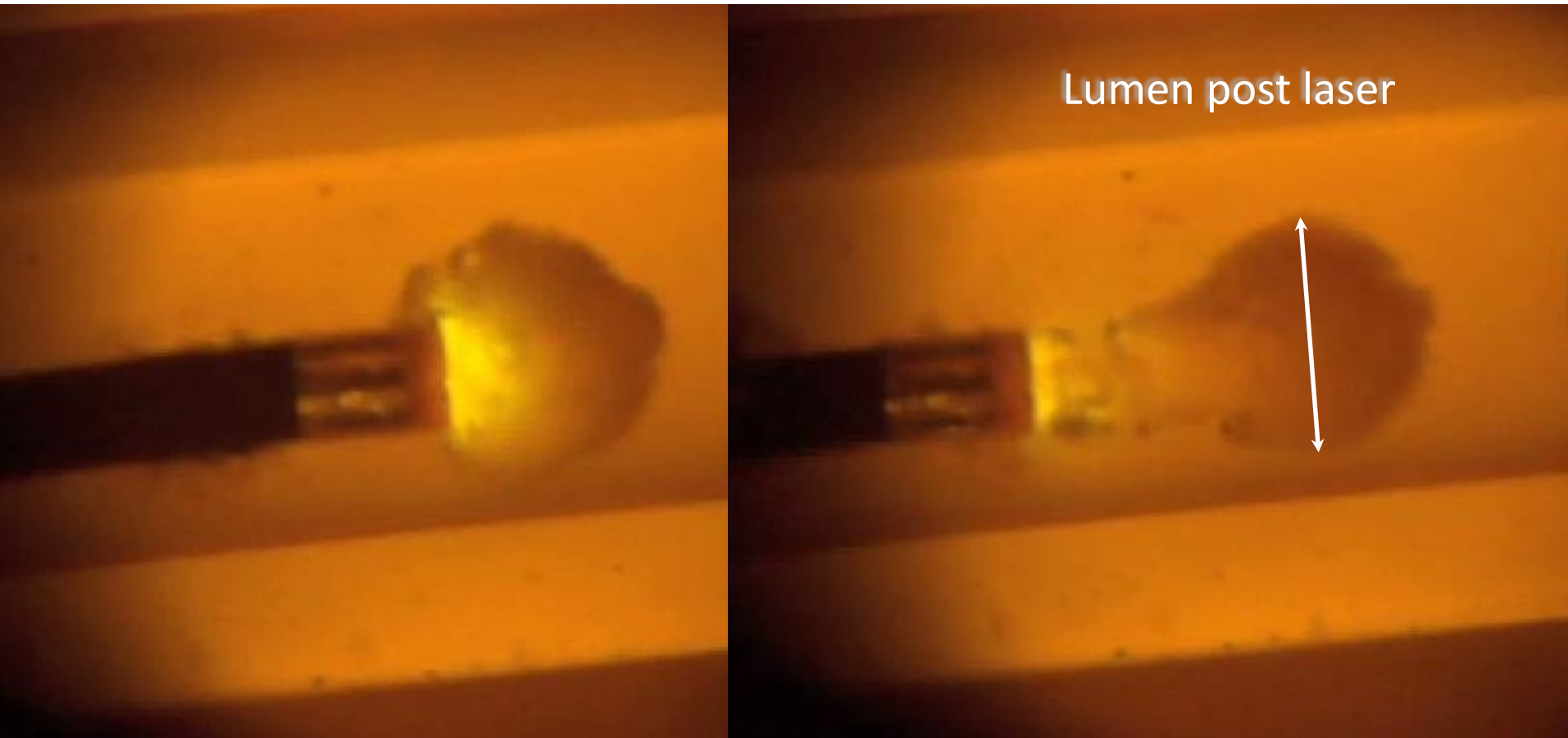


Lumen diameter with
SLOW ADVANCEMENT
(less than 1 mm per second.)

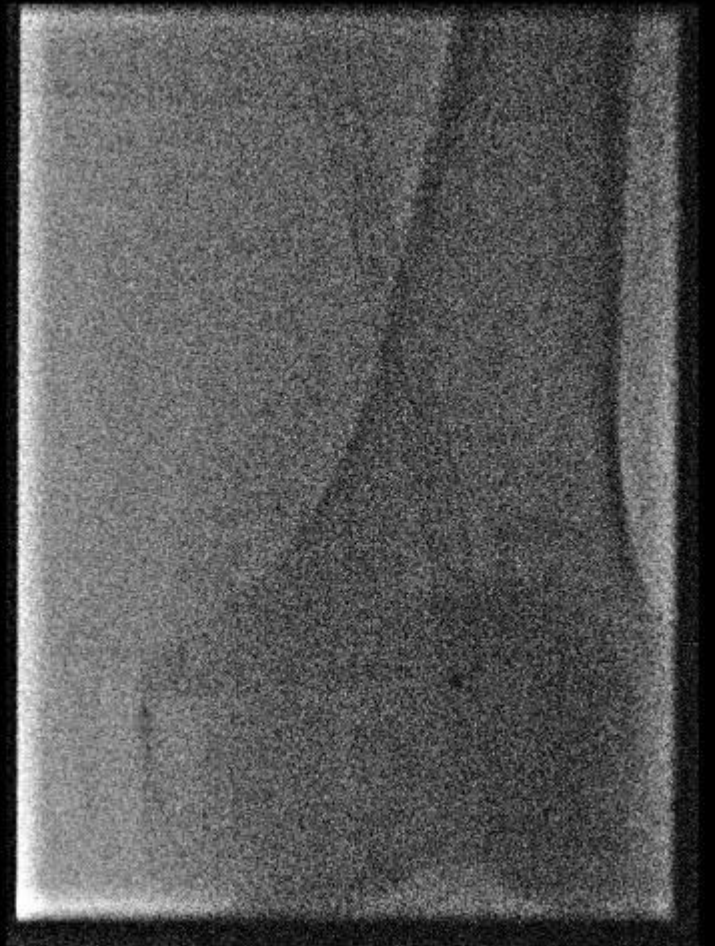
2.3 Turbo Elite in 6mm



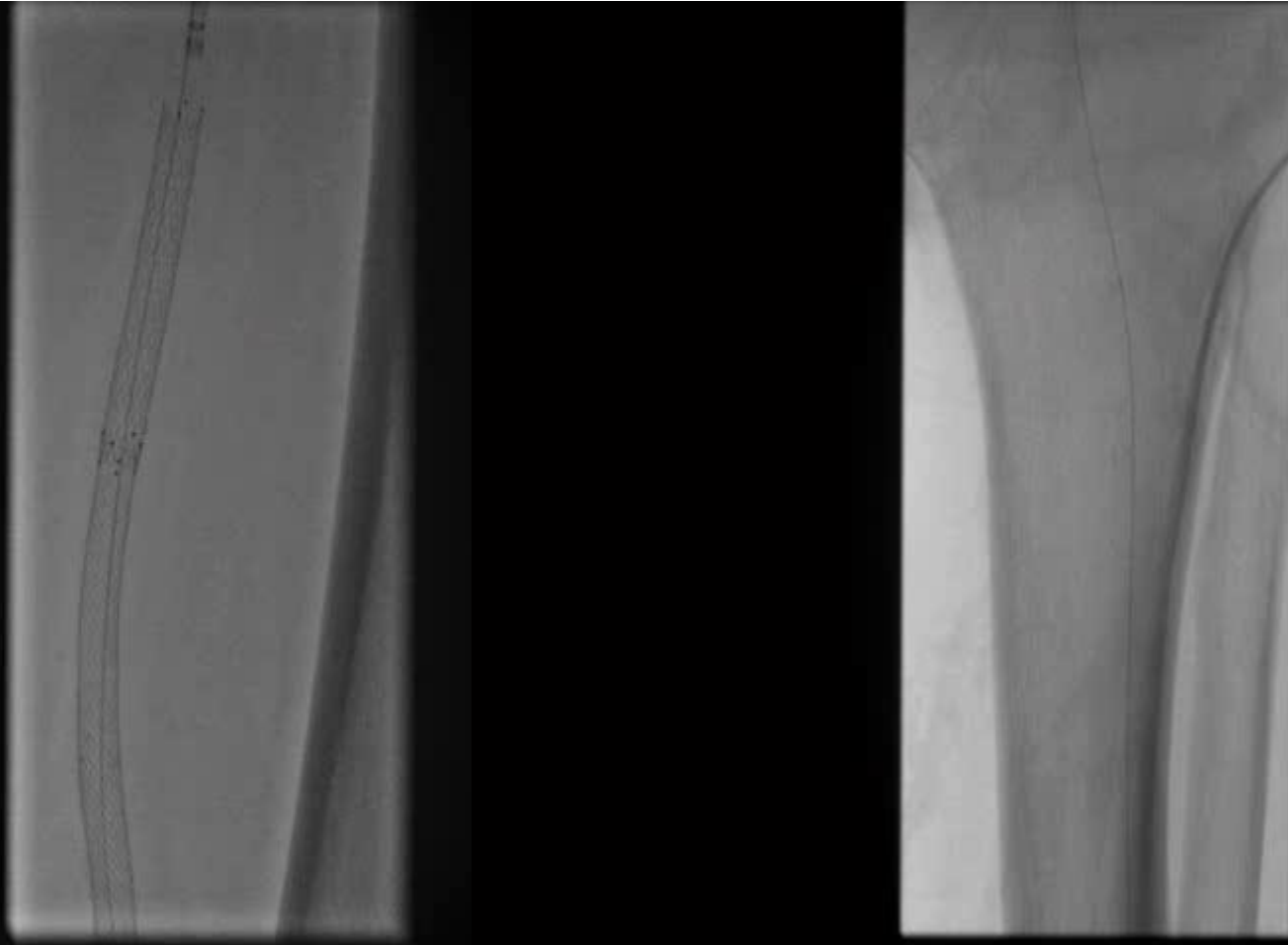
80 pulses /sec create a ***forward*** acting vapor bubble that can create a lumen ***larger than the Laser*** itself



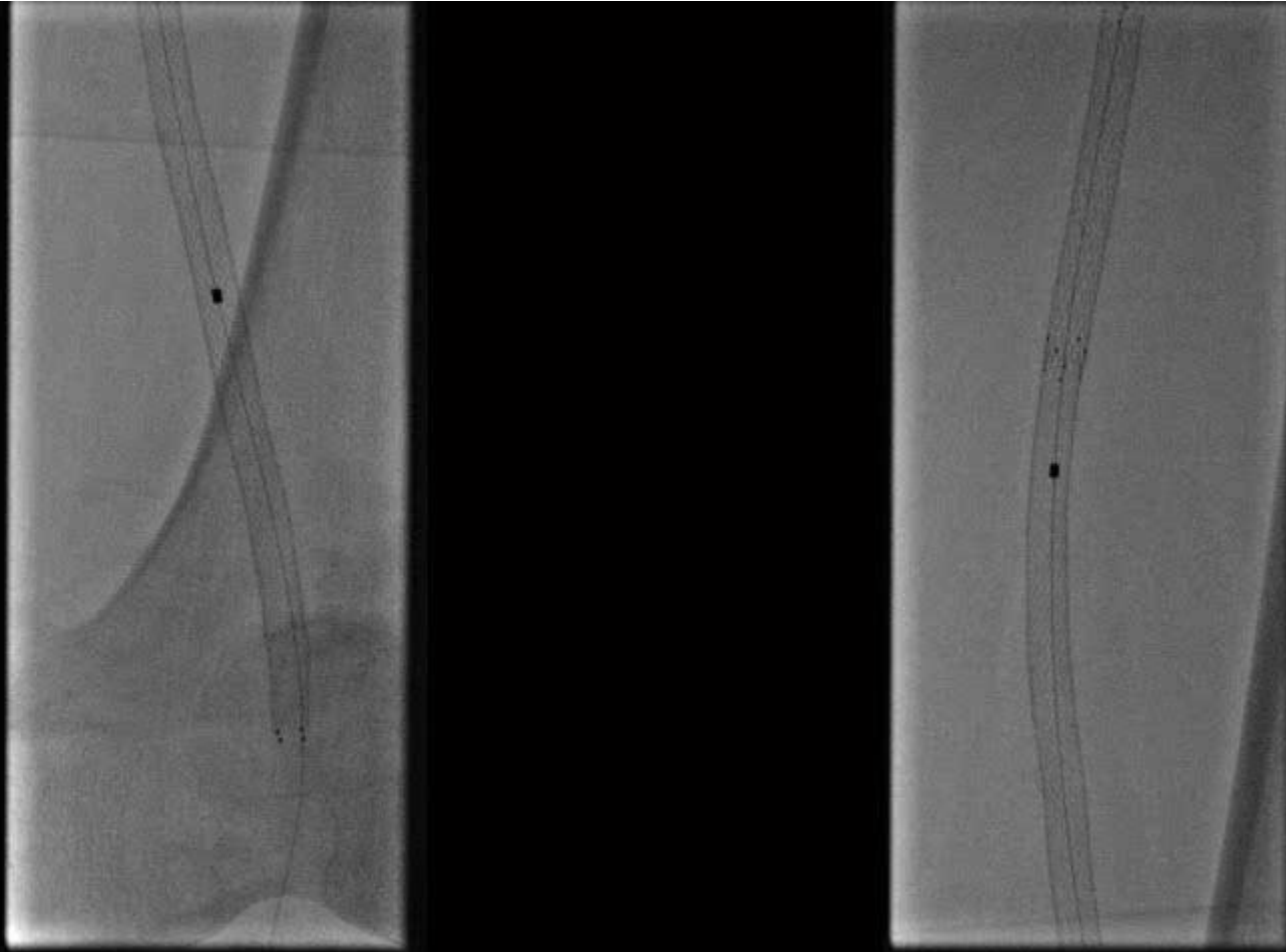
“Laser Atherectomy”



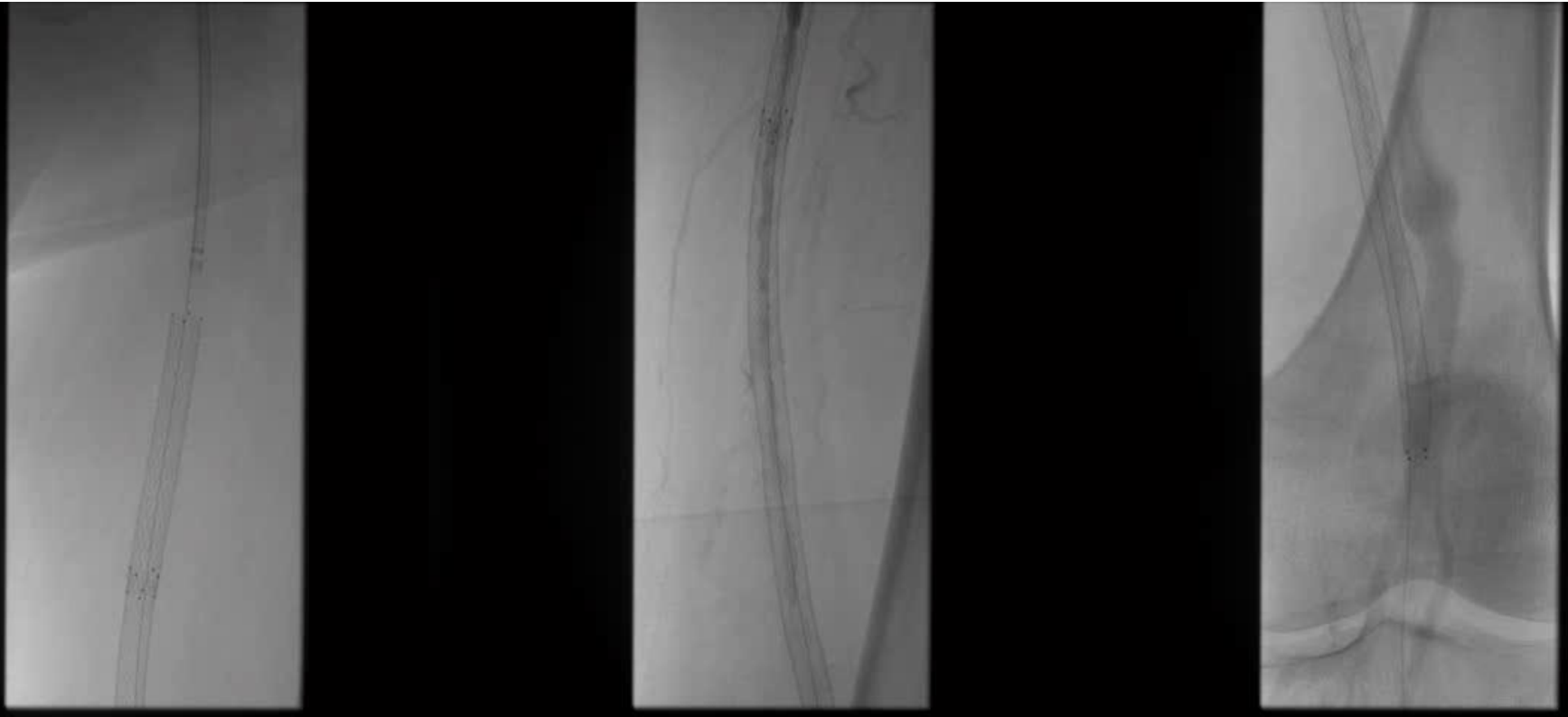
“Laser Atherectomy”



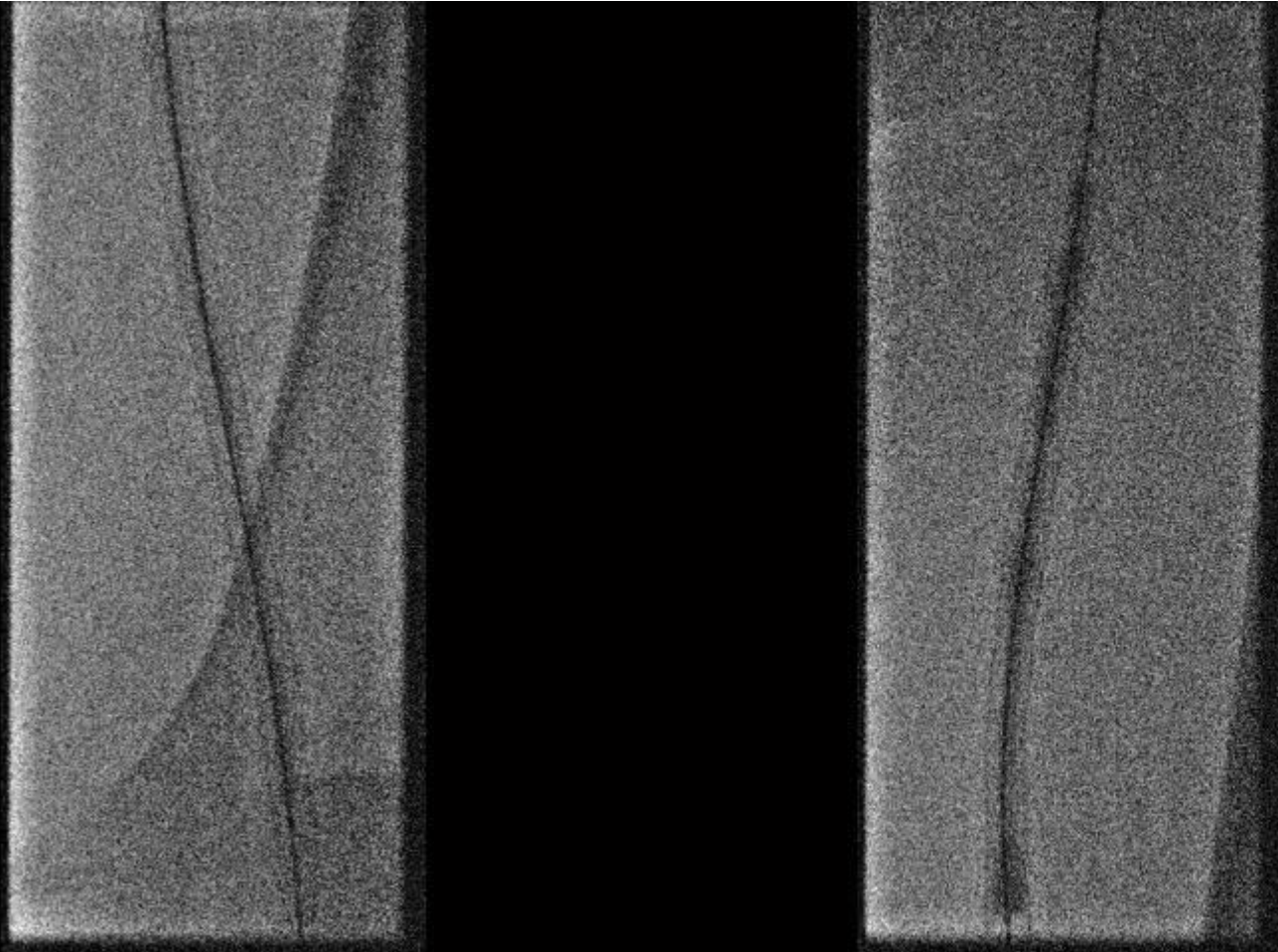
“Laser Atherectomy”



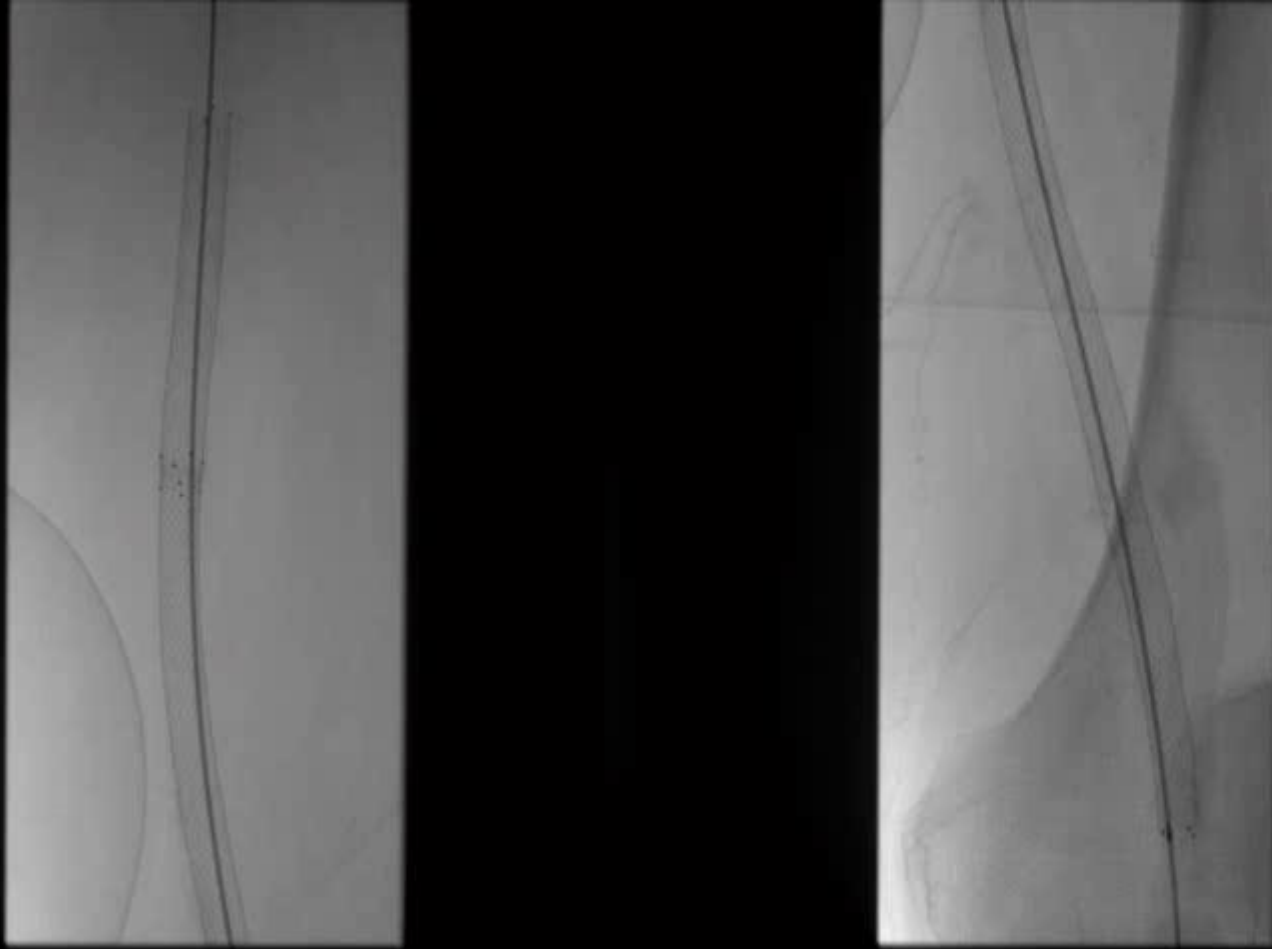
“Laser Atherectomy” *(result after laser)*



Paclitaxel DCB: 6.0 x 150 mm & 6.0 x 120 mm



Laser + DCB



Laser + DCB



Terapia alla dimissione

- Pantoprazolo 20 mg
- Acido acetil-salicilico 100 mg
- Clopidogrel 75 mg
- Atorvastatina 20 mg
- Ramipril 5 mg



Dopo il primo mese... cosa fare ???

Riassumendo

Ateromasia carotidea

STEMI due anni fa

PTA femorale sei mesi fa

Re-PTA femorale un mese fa



Quale terapia a lungo termine ???

- Continuare con un solo anti-aggregante ?
- Prolungare Dapt ?
- Un solo anti-aggregante + LMWH ?
- Terapia anticoagulante



DAPT prolungata ???

In the **PEGASUS-TIMI54**, the addition of ticagrelor 90 mg twice a day or 60 mg twice a day on top of low-dose aspirin in stable patients with prior MI (1-3 years) was investigated. Among patients with known LEAD (5% of the entire population), ticagrelor (pooled doses) **reduced significantly the risk of major adverse limb outcomes (acute limb ischaemia and peripheral revascularization) [HR 0.65 (95% CI 0.44-0.95)]**. In addition, in patients with LEAD, ticagrelor showed the greatest benefit, with an absolute risk reduction (ARR) of 4.1% [NNT= 25] for MACE and an absolute excess of major bleeding of 0.12% [NNH = 834].

Therefore, long-term ticagrelor on top of low-dose aspirin may be considered in LEAD patients with prior MI (<3 years).



Anticoagulante ???

The Current ESC Guidelines for PAD Management Recommend Treatment of Symptomatic PAD

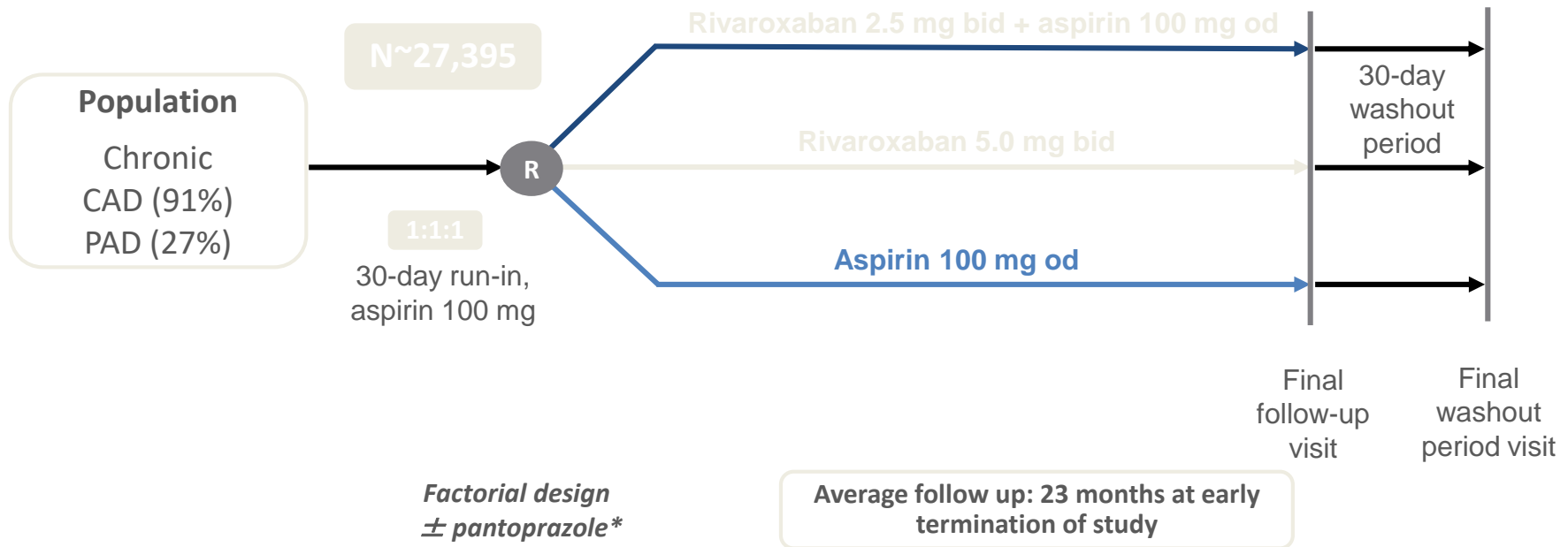
2017 ESC guideline recommendations for antithrombotic therapies in PAD

- ◆ SAPT is recommended for all patients with symptomatic PAD
- ◆ DAPT is recommended only for a limited period of time after certain revascularization procedures

Patients with...	Recommendation	Class
Symptomatic PAD	Antiplatelet therapy is recommended	Ic
Lower extremity PAD	In patients requiring antiplatelet therapy, clopidogrel may be preferred over aspirin	IIb
	Anticoagulation with VKAs may be considered after autogenous vein infrainguinal bypass	IIb
	DAPT (aspirin plus clopidogrel) for ≥ 1 month should be considered after infra-inguinal stent implantation	IIa
	DAPT (aspirin plus clopidogrel) may be considered in the case of below-knee bypass with a prosthetic graft	IIb
	Long-term SAPT is recommended in all patients who have undergone revascularization	
	SAPT is recommended after infrainguinal bypass surgery	



A Dual Pathway Inhibition Approach Targeting Chronic Patients with CAD or PAD was Investigated in COMPASS



Antithrombotic investigations* were stopped 1 year ahead of expectations in Feb 2017 due to overwhelming efficacy in the rivaroxaban 2.5 mg bid + aspirin arm

*Patients who were not receiving a proton pump inhibitor (PPI) were randomised to pantoprazole or placebo (partial PPI pantoprazole component of the study is continuing; data will be communicated once complete)



COMPASS Included over 7000 Patients with Symptomatic PAD or Concomitant CAD and PAD

	Number of patients
All patients with PAD	7470
Symptomatic lower-extremity PAD	4129
Carotid disease	1919
CAD + asymptomatic PAD (ABI <0.90)	1422

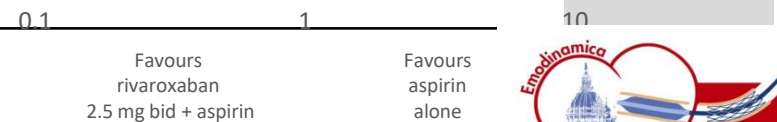
- PAD was defined according to patient presentation at enrolment
- In addition, a patient could be defined as a PAD patient based on medical history and/or measurement of ABI at baseline visit
 - The latter category added patients with CAD and asymptomatic PAD patients into the overall PAD subgroup
- Median follow-up: 21 months



Rivaroxaban Vascular Dose 2.5 mg bid + Aspirin Significantly ↓ Both CV & Limb Events incl. Amputations vs Aspirin in PAD

Pre-specified PAD outcomes*	Riva 2.5 mg bid + aspirin n (%)	Aspirin n (%)	HR	HR (95% CI)	p-value
CV death, stroke, MI (MACE: major adverse cardiac events)	126 (5)	174 (7)	0.72		0.0047
Acute limb ischaemia or chronic limb ischaemia (MALE: major adverse limb events)	30 (1)	56 (2)	0.54		0.0054
Major amputation	5 (0.2)	17 (0.7)	0.30		0.011
All vascular amputations	11 (0.4)	28 (1)	0.40		0.0069
MACE or MALE, or major amputation	157 (6)	225 (9)	0.69		0.0003

*Crude incidence over median follow-up of 21 months



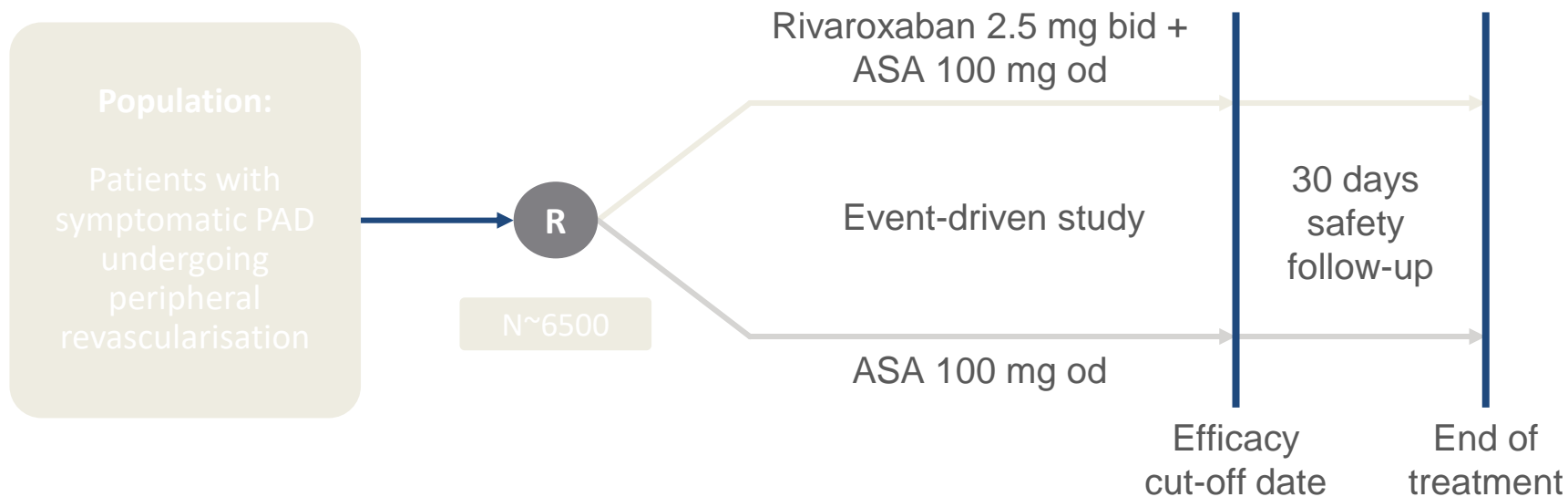
Bleeding Rates Increased But Low, in Particular No Significant Increase in Fatal or Critical Organ Bleeding

Crude incidence over mean follow-up of 23 months	Riva 2.5 mg bid + aspirin n (%)	Aspirin n (%)	HR (95% CI)	p-value
Major bleeding	77 (3)	48 (2)	1.61 (1.12–2.31)	0.0089
Fatal	4 (0.2)	3 (0.1)	–	–
Intracranial	5 (0.2)	9 (0.4)	0.56 (0.19–1.66)	–
Fatal or symptomatic bleeding into a critical organ	21 (1)	19 (1)	1.10 (0.59–2.05)	–
Pre-specified net clinical benefit (CV death, MI, stroke, MALE, major amputation, fatal bleeding or critical organ bleeding)	169 (7)	234 (9)	0.72 (0.59–0.87)	0.0008
All-cause mortality	129 (5)	142 (6)	0.91 (0.72–1.16)*	–



VOYAGER PAD will test Rivaroxaban Vascular Dose 2.5 mg bid + Aspirin in Patients with PAD in the Acute Phase

Objective: To evaluate the efficacy and safety of rivaroxaban 2.5 mg bid in addition to aspirin compared with aspirin alone to reduce the risk of thrombotic vascular events in **patients with PAD undergoing peripheral (lower extremity) revascularisation procedures**



Terapia dopo il primo mese

- Pantoprazolo 20 mg
- Acido acetil-salicilico 100 mg
- Rivaroxaban 2,5 mg X 2
- Atorvastatina 20 mg
- Ramipril 5 mg

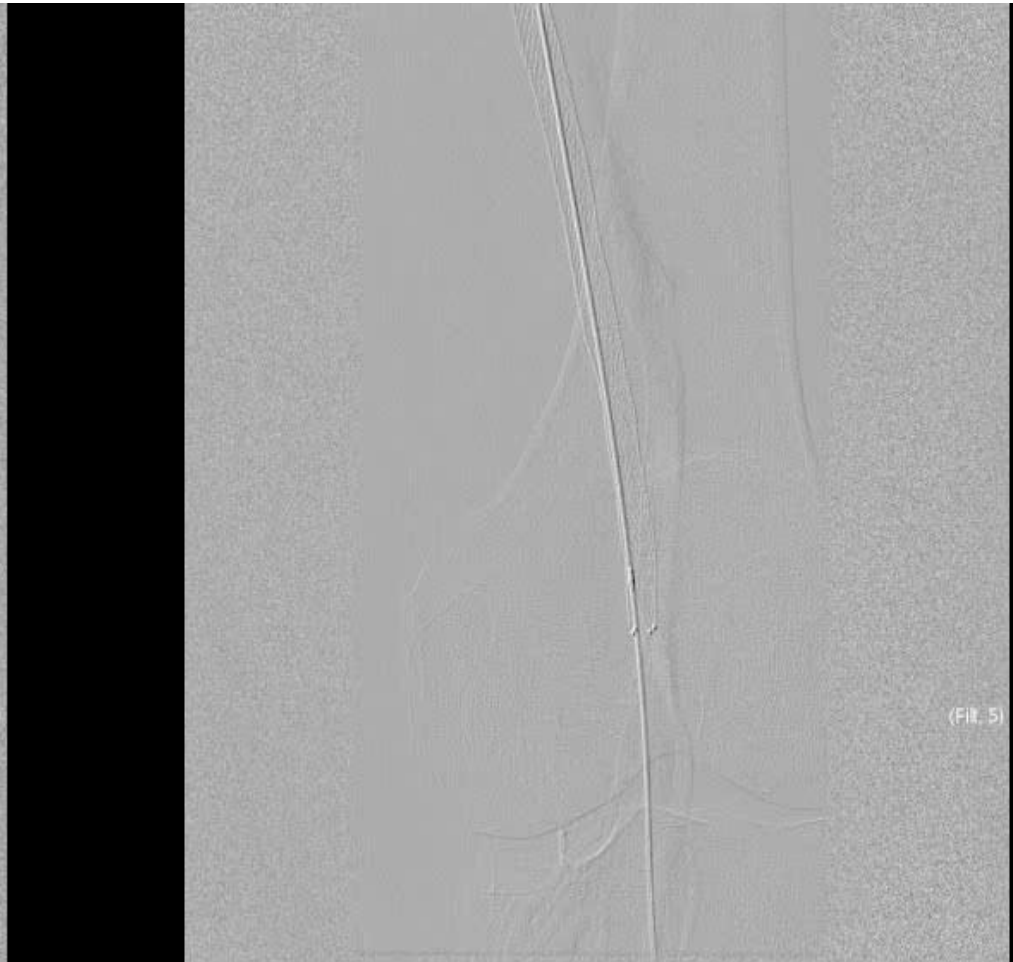
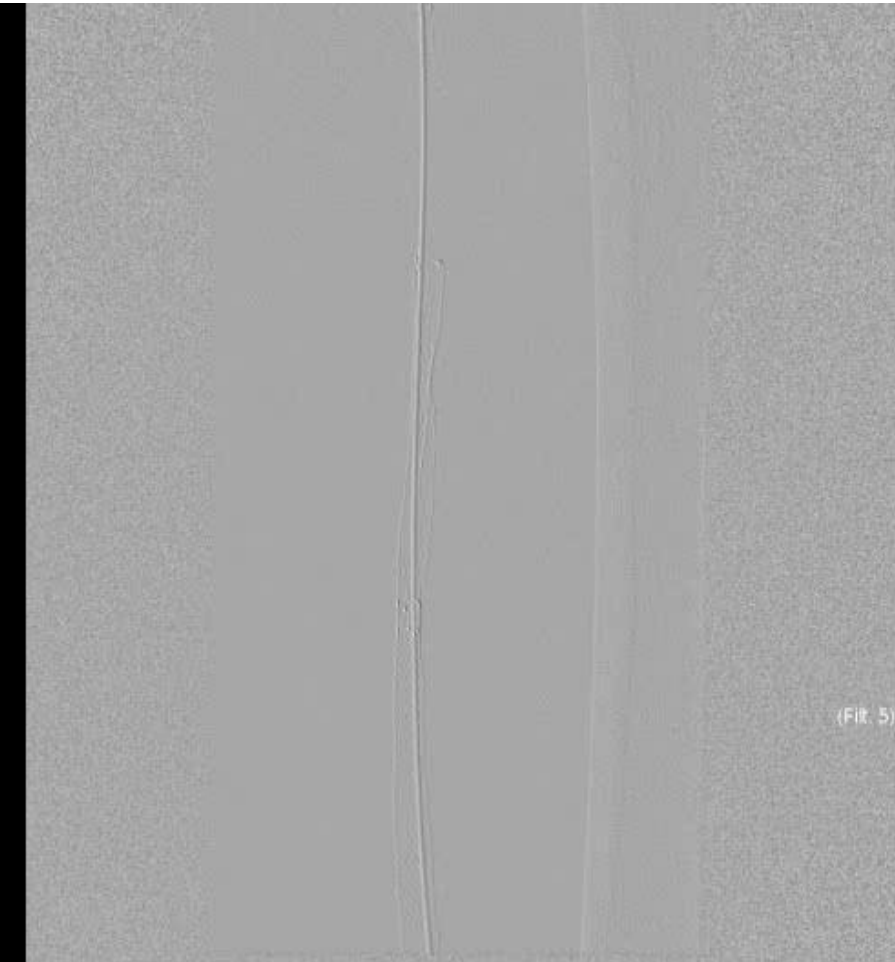


Follow-up a sei mesi

- **Asintomatico** per angina pectoris
- **Claudicatio** di polpaccio a sinistra (IML 200 m)
- **Eco-colo-doppler AI**: dubbio per ristrenosi intrastent SFA sin.



Controllo angiografico a sei mesi



Messaggi da portare a casa

- La PAD è importante anche per i cardiologi

Grazie !

vista

re
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- il VOYAGER, guideranno la nostra pratica clinica futura

