A Diabetic patient with ACS undergoing PCI

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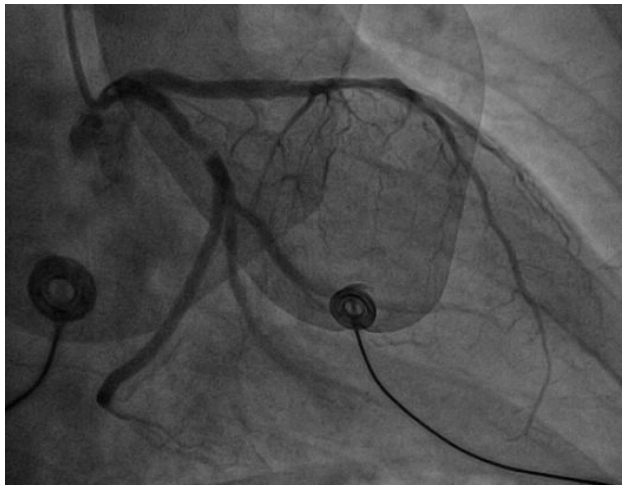
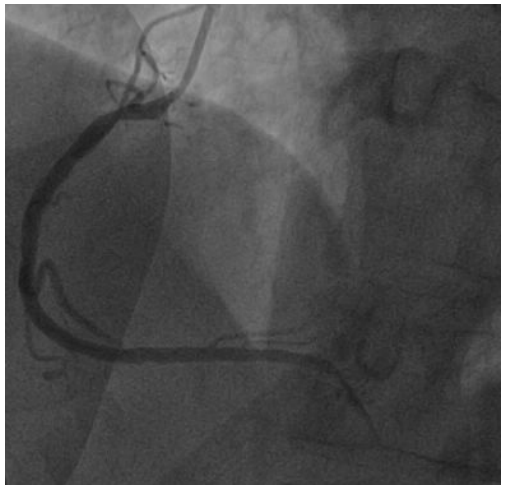
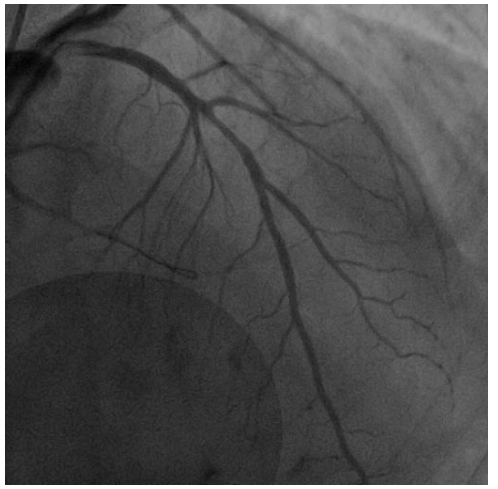
Case

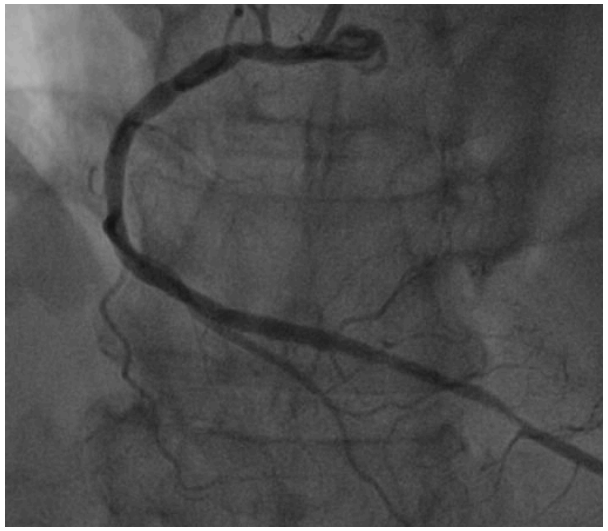
- Male, 63 years old
- Risk Factors for CAD: hypertension, hypercholesterolemia, T2DM
- History of PAD
- March 2017: inferior ST elevation MI and primary PCI on CFX in 3 vessel CAD
- Discharged 5 days later: Aspirin, Ticagrelor 90 mg bid, BB, High dose statin, ARB, metformin
- EF > 60%

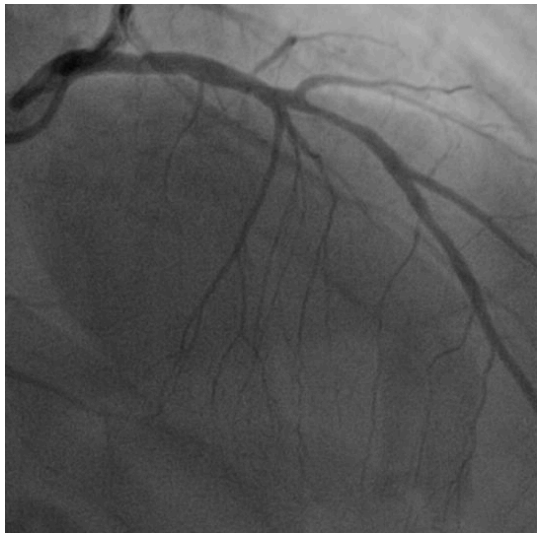


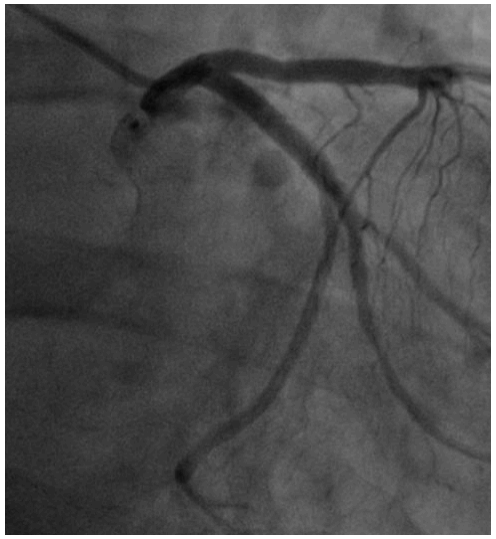




- June 2017
- NSTEMI: chest pain, raised Troponin, no ECG changes
- Coronary angio < 24 hours
- Blood samples: cLDL 84 mg/dl
- Ongoing Medical therapy: Aspirin, Ticagrelor 90 mg bid, BB, High dose statin plus ezetimibe, ARB, metformin

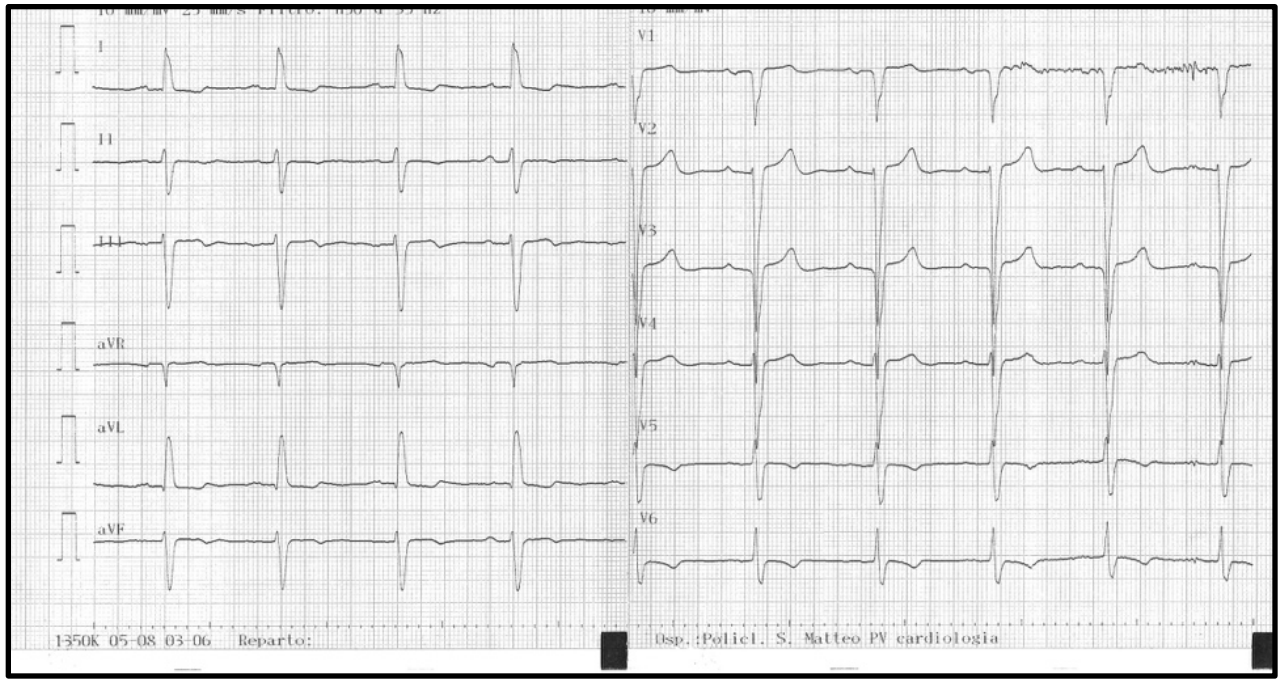






- June 2017
- NSTEMI
- Coronary angio: CFX ok and PCI on LAD (before FFR evaluation) and on distal RCA
- Discharged 4 days later: Aspirin, Ticagrelor 90 mg bid, BB, High dose statin plus ezetimibe, ARB, metformin
- PCK9 Inh????
- EF > 60%

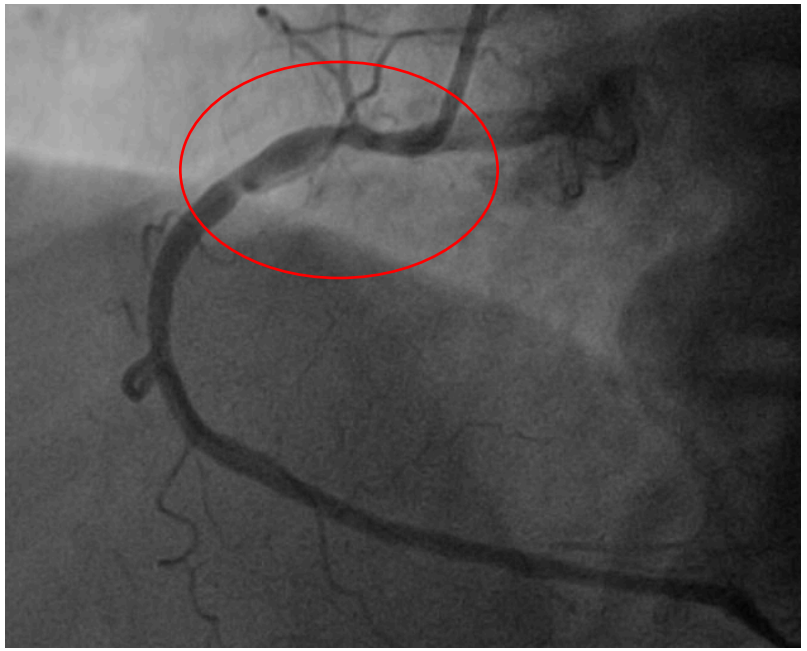
- 18 days later
- Onset of typical chest pain
- Directly access to our ER
- Troponin raised at first evaluation
- cLDL 78 mg/dl; HbA1c 7.6%
- GRACE SCORE 106
- CRUSADE BLEED 31

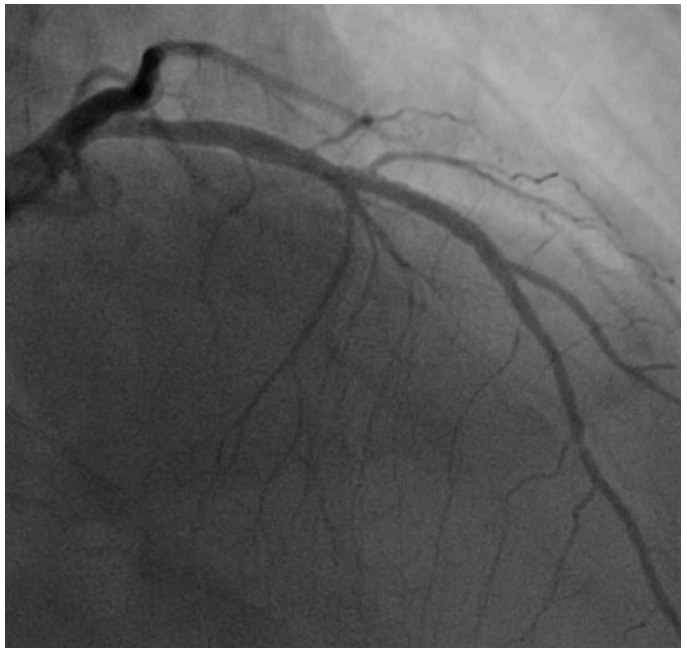


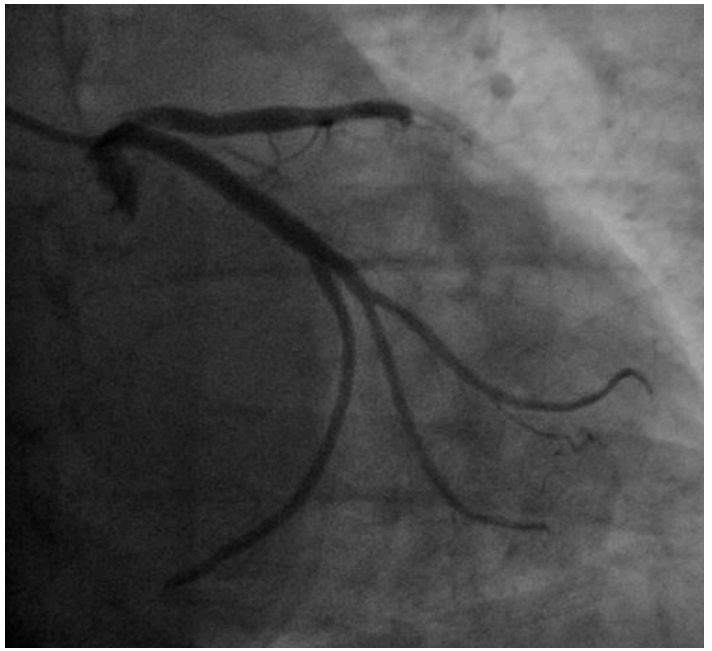
Which antithrombotic therapy?

- Fondaparinux
- Enoxaparin
- UHF
- Upstream GpI
- Switch to prasugrel after PCI

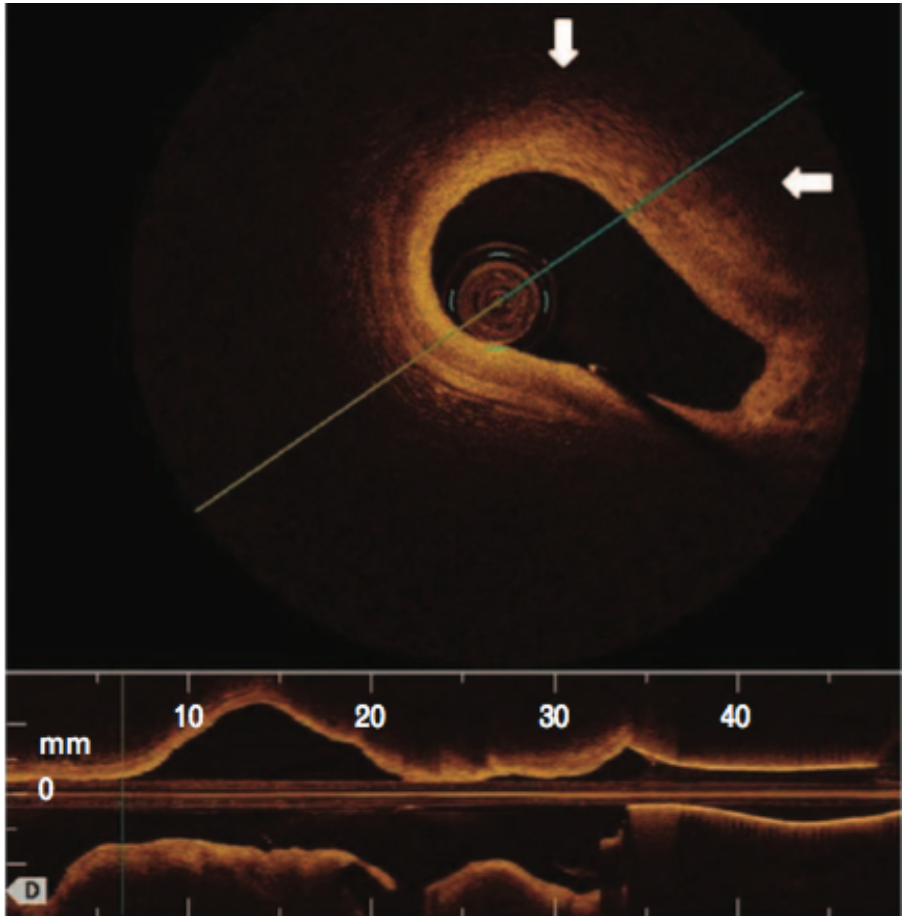
July 2017

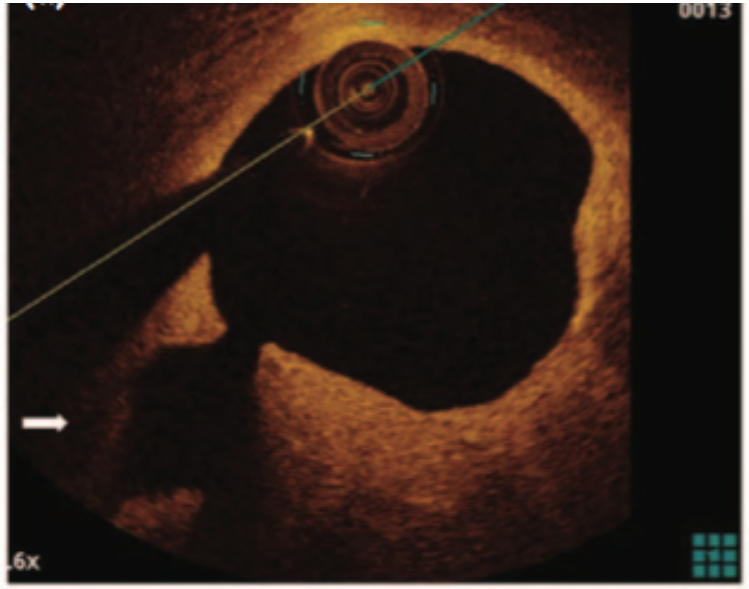


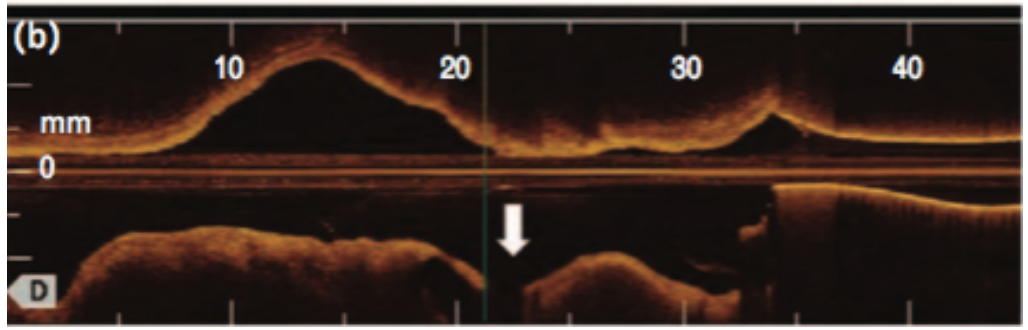




OCT of the RCA







PCI ON RCA: WHICH Medical Therapy at discharge?

- Aspirin
- Ticagrelor
- BB and ARB
- High dose statin plus ezetimibe
- Insulin
- Adding PCSk9 inhibitors?
- More?

Case Conclusion

- Despite the improvement of devices and antithrombotic therapy, frequent flyer with ACS remanin a challenge
- T2DM is one of the major risk factors associated with CAD developement
- In these particular setting aggressive medical therapy appears as mandatory