Manejo a largo plazo del SCA
Prioridades

Dr. Iñaki Lekuona
Sº Cardiología HGU
Osakidetza

GUIÓN

1.-Introducción: Importancia de las recomendaciones al alta

2.-Cambios terapéuticos del estilo de vida: Dieta, Ejercicio, Tabaco

3.-Fármacos: Antiagregantes, Betabloqueantes, IECAs /ARA2, ARM

4.-Hipocolesterolemiantes, PA, vacuna GRIPE

RECOMENDACIONES

Recommendation on hospital-based programmes

Recommendations	Class[a]	Level[b]	GRADE	Ref[c]
All patients with cardiovascular disease must be discharged from hospital with clear guideline-orientated treatment recommendations to minimize adverse events.	I	B	Strong	250, 555

Chow CK et al Circulation 2010;121:750–758

Bramlage P et al Heart 2010;96: 604–609

INFORME DE ALTA basado en las GUÍAS que oriente AL MÉDICO Y AL PACIENTE

Recommendation for specialized prevention centres

Recommendations	Class[a]	Level[b]	GRADE	Ref[c]
All patients requiring hospitalization or invasive intervention after an acute ischaemic event should participate in a cardiac rehabilitation programme to improve prognosis by modifying lifestyle habits and increasing treatment adherence.	IIa	B	Strong	205, 250

Piepoli MF et al Eur J Cardiovasc Prev Rehabil 2010;17:1–17

Chow CK et al Circulation 2010;121:750–758

REHABILITACIÓN CARDIACA

Mejorar el pronóstico, modificando estilos de vida, incrementar adherencia al tratamiento

AHA/ACC GUIDELINES STEMI 2013

ABORDAJE HOLÍSTICO

Risk factor modification/ lifestyle interventions

- *Smoking cessation*

Medications

- *Antithrombotic therapies*
- *Beta blockers*
- *ACE inhibitors /ARBs /MRA*
- *Statins*

Psychosocial factors

- Sexual activity
- Gender-specific issues
- Depression, stress, and anxiety
- Alcohol use
- Culturally sensitive issues

Provider follow -up

- Cardiologist
- Primary care provider
- Advanced practice nurse/ physician
- Other relevant medical specialists
- Electronic personal health records

- *Influenza vaccination*

Management of comorbidities

- Overweight/ obesity
- *Lipids*
- *Hypertension*
- Diabetes
- HF
- Arrhythmia/ arrhythmia risk

Patient /family education

- Plan of care for acute MI
- Recognizing symptoms of MI
- Activating EMS, signs and symptoms for urgent vs emergency evaluations
- CPR training for family members

Frecuencia cardiaca

Modificado de JACC 2013

CAMBIOS TERAPEUTICOS DEL ESTILO DE VIDA

DIETA

- Saturated fatty acids to account for <10% of total energy intake, through replacement by polyunsaturated fatty acids.
- Trans-unsaturated fatty acids: as little as possible, preferably no intake from processed food, and <1% of total energy intake from natural origin.
- <5 g of salt per day.
- 30–45 g of fibre per day, from wholegrain products, fruits, and vegetables.
- 200 g of fruit per day (2–3 servings).
- 200 g of vegetables per day (2–3 servings).
- Fish at least twice a week, one of which to be oily fish.
- Consumption of alcoholic beverages should be limited to two glasses per day (20 g/day of alcohol) for men and one glass per day (10 g/day of alcohol) for women.

ACTIVIDAD FÍSICA

Recommendations	Class[a]	Level[b]
Healthy adults of all ages should spend 2.5–5 h a week on physical activity or aerobic exercise training of at least moderate intensity, or 1–2.5 h a week on vigorous intense exercise. Sedentary subjects should be strongly encouraged to start light-intensity exercise programmes.	I	A
Physical activity/aerobic exercise training should be performed in multiple bouts each lasting ≥10 min and evenly spread throughout the week, i.e. on 4–5 days a week.	IIa	A
Patients with previous acute myocardial infarction, CABG, PCI, stable angina pectoris, or stable chronic heart failure should undergo moderate-to-vigorous intensity aerobic exercise training ≥3 times a week and 30 min per session. Sedentary patients should be strongly encouraged to start light-intensity exercise programmes after adequate exercise-related risk stratification.	I	A

PRIORIDAD 1

EHJ 2012

TABACO

Guías AHA/ACC Prevención Secundaria 2011
Guías ESC 2012

OBJETIVO: **Cese completo. Evitar exposición tabaco ambiental**

1. Los pacientes deben ser preguntados acerca del tabaco en cada visita B

2. Cada fumador debe ser aconsejado para dejar de fumar en cada visita A

3. El deseo de abandono del tabaco debe ser valorado en cada visita C

4. Los pacientes deben ser aconsejados y debe formularse un plan de deshabituación que puede incluir farmacoterapia y/o referencia a un programa estructurado A

5. Se recomienda citar a los pacientes para seguimiento C

6. Todos los pacientes deben ser advertidos en cada visita para evitar la exposición al tabaco en el trabajo, en casa ó en lugares públicos B

Circulation 2011 EHJ 2012

EUROPREVENT 2013: TABACO

3000 cardiólogos de la SEC encuestados. Solo 328 (11%) contestan

44, 63% H, 76% cardiólogos clínicos, 18% intervencionistas.
29% fumadores activos, 4% exfumadores

Solo el 22% tenían folletos para dejar de fumar a mano
Solo 14% tenían COXÍMETRO.
22% no habían oído nunca hablar del test de Fagerström usado para medir el nivel de dependencia a la nicotina.
60% consideraban su entrenamiento insuficiente
71% deseaban mejoran sus aptitudes para ayudar a dejar el tabaco

76% afirmaban recomendar siempre el cese del tabaco, sólo el 40% hacía seguimiento

73% no prescribían fármacos para deshabituar por falta de familiaridad con los mismos, 11% por temor a efectos adversos

Dra. Regina Dalmau

CONCIENCIACIÓN, TIEMPO, FORMACIÓN

RESÚMENES COCHRANE

Evidencia científica independiente de alta calidad para la toma de decisiones en atención sanitaria

Intervenciones farmacológicas para el abandono del hábito de fumar: resumen y metanálisis de redes

Kate Cahill, Sarah Stevens, Rafael Perera, Tim Lancaster

12 revisiones Cochrane de tratamientos diferentes

Remplazo de nicotina (TRN); antidepresivos (bupropión y nortriptilina); agonistas parciales de los receptores de nicotina (vareniclina y citisina); ansiolíticos; antagonistas selectivos tipo 1 de los receptores de canabinoides (rimonabant); clonidina; lobelina; dianiclina; mecamilamina; Nicobrevin; antagonistas opioides; vacunas de nicotina; y acetato de plata

CONCLUSIONES

El TRN, el bupropión y la vareniclina mejoran las probabilidades de abandono del hábito de fumar, con un bajo riesgo de efectos perjudiciales.

El uso de TRN combinado es tan eficaz como la vareniclina y más eficaz que los tipos únicos de TRN.

La citisina tiene potencial como tratamiento seguro, eficaz y asequible.

La nortriptilina mejora las probabilidades de abandono, con pocas pruebas de eventos perjudiciales.

Es necesario continuar la monitorización de la seguridad de la vareniclina.

The Cochrane Library 2013, Issue 5

TABACO

EUROASPIRE IV

Prevalence of persistent smoking*

Interview

Casi la mitad de los pacientes siguen fumando tras un evento coronario

PRIORIDAD 2

ASPIRINA

GUÍA ESC

Aspirin should be given to all patients without contraindications at an initial loading dose of 150–300 mg, and at a maintenance dose of 75–100 mg daily long-term regardless of treatment strategy.	I	A

GUÍA ACC/AHA

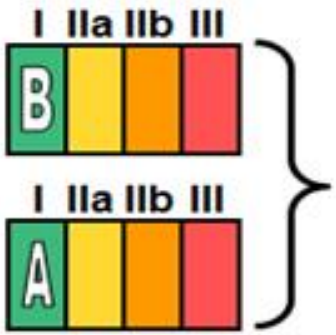
Aspirin (75-162 mg daily) if known CAD† or NSTE-ACS‡

Aspirin (81-325 mg daily) following PCI or fibrinolytic therapy for a STEMI*

Aspirin (preferentially at 81 mg daily) following PCI for a NSTE-ACS# or a STEMI* or fibrinolytic therapy for a STEMI*

†‡Smith SC Jr. et al. *JACC* 2011;58:2432-2446
#Wright RS et al. JACC 2011;57:e215-367
*O'Gara PT et al. *JACC* 2013;61:e78-e140
†#Jneid H et al. *JACC* 2012;60:645-681

ASPIRINA



Aspirin (162-325 mg daily) for at least 1 month after bare metal stent implantation (Class I, Level B), at least 3 months after sirolimus-eluting stent implantation (Class I, Level B), and at least 6 months after paclitaxel-eluting stent implantation (Class I, Level B) after which aspirin (75-162 mg daily) should be continued indefinitely (Class I, Level A for a bare metal stent and Class I, Level B for a drug eluting stent)

Aspirin (75-162 mg daily) as the initial dose after stent implantation in those at higher bleeding risk

Aspirin (100-325 mg daily) following CABG surgery

ASPIRINA SIEMPRE

INHIBIDORES DEL RECEPTOR P2Y12

PROMPT
POTENT
PREDICTABLE

SCACEST PERIPROCEDIMIENTO

GUÍA ESC SCACEST 2012

• Prasugrel in clopidogrel-naive patients, if no history of prior stroke/TIA, age <75 years.	I	B
• Ticagrelor.	I	B
• Clopidogrel, preferably when prasugrel or ticagrelor are either not available or contraindicated.	I	C

SCASEST MEDIO-LARGO PLAZO

DAPT with a combination of aspirin and prasugrel or aspirin and ticagrelor is recommended (over aspirin and clopidogrel) in patients treated with PCI.	I	A
DAPT with aspirin and an oral ADP receptor antagonist must be continued for up to 12 months after STEMI, with a strict minimum of:	I	C
• 1 month for patients receiving BMS	I	C
• 6 months for patients receiving DES	IIb	B

GUÍA ACC/AHA

Clopidogrel (75 mg daily), prasugrel (10 mg daily), or ticagrelor (90 mg twice daily) in addition to aspirin for 1 year following PCI for a NSTE-ACS† or a STEMI‡

European Heart Journal (2012) 33, 2569–2619

INHIBIDORES DEL RECEPTOR P2Y12

SCASEST

Ticagrelor (180-mg loading dose, 90 mg twice daily) is recommended for all patients at moderate-to-high risk of ischaemic events (e.g. elevated troponins) , regardless of initial treatment strategy and including those pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced).	I	B
Prasugrel (60-mg loading dose, 10-mg daily dose) is recommended for $P2Y_{12}$-inhibitor-naïve patients (especially diabetics) in whom coronary anatomy is known and who are proceeding to PCI unless there is a high risk of life-threatening bleeding or other contraindications.[d]	I	B
Clopidogrel (300-mg loading dose, 75-mg daily dose) is recommended for patients who cannot receive ticagrelor or prasugrel.	I	A

Clopidogrel (75 mg daily) or ticagrelor (90 mg twice daily) in addition to aspirin for up to 1 year following a NSTE-ACS managed conservatively

European Heart Journal Advance Access published April 11, 2014

European Heart Journal
doi:10.1093/eurheartj/ehu160

CLINICAL RESEARCH
Acute coronary syndromes

Ticagrelor vs. clopidogrel in patients with non-ST-elevation acute coronary syndrome with or without revascularization: results from the PLATO trial

Daniel Lindholm[1], Christoph Varenhorst[1], Christopher P Cannon[2], Robert A Harrington[3], Anders Himmelmann[4], Juan Maya[5], Steen Husted[6], Philippe Gabriel Steg[7,8,9,10], Jan H Cornel[11], Robert F Storey[12], Susanna R Stevens[13], Lars Wallentin[1], and Stefan K James[1]*

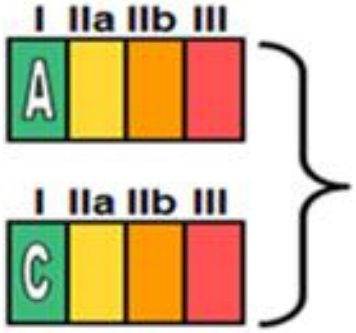
Aims The optimal platelet inhibition strategy for ACS patients managed without revascularization is unknown.
We aimed to evaluate efficacy and safety of ticagrelor vs. clopidogrel in the non-ST-elevation acute coronary syndrome (NSTE-ACS) subgroup of the PLATO trial, in the total cohort, and in the subgroups managed with and without revascularization within 10 days of randomization.

Methods and results We performed a retrospective analysis of the primary endpoint of cardiovascular death/myocardial infarction/stroke. Among 18 624 PLATO patients, 11 080 (59%) were categorized as NSTE-ACS at randomization. During the initial 10 days, 74% had angiography, 46% PCI, and 5% CABG. In NSTE-ACS patients, the primary endpoint was reduced with ticagrelor vs. clopidogrel [10.0 vs. 12.3%; hazard ratio (HR) 0.83; 95% confidence interval (CI) = 0.74–0.93], as was myocardial infarction (6.6 vs. 7.7%; HR 0.86; 95% CI = 0.74–0.99), cardiovascular death (3.7 vs. 4.9%; HR 0.77; 95% CI = 0.64–0.93), and all-cause death (4.3 vs. 5.8%; HR 0.76; 95% CI = 0.64–0.90). Major bleeding rate was similar between treatment groups (13.4 vs. 12.6%; HR 1.07; 95% CI = 0.95–1.19), but ticagrelor was associated with an increase in non-CABG major bleeding (4.8 vs. 3.8%; HR 1.28; 95% CI = 1.05–1.56). Within the first 10 days, 5366 (48.4%) patients were managed without revascularization. Regardless of revascularization or not, ticagrelor consistently reduced the primary outcome (HR 0.86 vs. 0.85, interaction $P = 0.93$), and all-cause death (HR 0.75 vs. 0.73, interaction $P = 0.89$) with no significant increase in overall major bleeding.

Conclusion In patients with NSTE-ACS, benefit of ticagrelor over clopidogrel in reducing ischaemic events and total mortality was consistent with the overall PLATO trial, independent of actually performed revascularization during the initial 10 days.

En pacientes con SCASEST el beneficio del ticagrelor vs. Clopidogrel en la reducción de los eventos isquémicos y la mortalidad total es independiente de que los pacientes se revascularicen o no

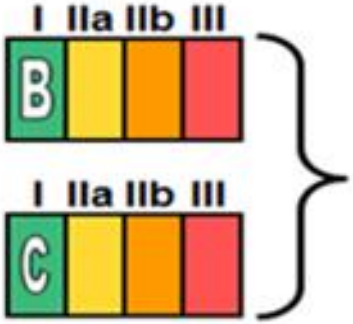
INHIBIDORES DEL RECEPTOR P2Y12



Fibrinólisis: CLOPIDOGREL+ASPIRINA

Clopidogrel (75 mg daily) in addition to aspirin for a minimum of 14 days (Class I, Level A) and up to 1 year (Class I, Level C) following fibrinolytic therapy for a STEMI‡

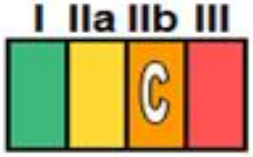
†Jneid H et al. JACC 2012;60:645-681
‡O'Gara PT et al. JACC 2013;61:e78-e140



Intolerantes Aspirina: CLOPIDOGREL,PRASUGREL ó TICAGRELOR

Clopidogrel (75 mg daily; Class I, Level B), prasugrel* (10 mg daily; Class I, Level C), or ticagrelor (90 mg twice daily; Class I, Level C) if aspirin intolerance or a true aspirin allergy following a NSTE-ACS

Se puede continuar inh P2Y12 >12 meses en DES



Continuation of a $P2Y_{12}$ receptor antagonist beyond 1 year may be considered in patients undergoing drug eluting stent placement

*In PCI treated patients

Jneid H et al. JACC 2012;60:645-681

ANTIAGREGANTES > 12 MESES

El riesgo de recurrencia de IM continua más allá del primer año del evento índice

Gullikssson 2009; Roger 2012

15–22% pacientes IM recurrente en 5 años

No hay estudios que valoren la eficacia de la DAPT prolongada en pacientes con SCA

por tanto

Las guías SCA recomiendan DAPT 12 meses Hamm 2011; Jneid 2012; Steg 2012; O'Gara 2013

Sin embargo hay datos que sugieren que la DAPT más allá de los 12 meses en pacientes con IM previo producen beneficio clínico CAPRIE steering committee 1996; Bhatt 2007

En el PLATO los pacientes tratados con Ticagrelor vs. Clopidogrel se beneficiaban del tratamiento más allá de los 12 meses disminuyendo el riesgo absoluto a lo largo del tiempo Wallentin 2009

Bhatt DL, et al. J Am Coll Cardiol 2007;49:1982–1988; CAPRIE steering committee. Lancet 1996;348:1329–1339; Gullikssson M, et al. Circ Cardiovasc Qual Outcomes 2009;2:178–185; Hamm CW, et al. Eur Heart J 2011;32:2999–3054; Jneid H, et al. Circulation 2012;126:875–910; Roger VL, et al. Circulation 2012;125:e2–e220; O'Gara PT, et al. Circulation 2013;127:e362–e425; Steg G, et al. Eur 2012;33:2569–2619; Wallentin L, et al. N Engl J Med 2009;361:1045–1057

ENSAYOS > 12 MESES

CAPRIE [CAPRIE steering committee 1996]

Clopidogrel versus ASA in patients at risk of ischaemic events

CHARISMA [Bhatt 2006]

Clopidogrel plus ASA versus ASA alone for the prevention of atherothrombotic events

CHARISMA: *Post-hoc* subgroup analysis[Bhatt 2007]

Patients with prior MI, prior stroke or symptomatic PAD

TRA2ºP TIMI 50 [Morrow 2012]

Vorapaxar for the secondary prevention of atherothrombotic events

TRA2ºP TIMI 50: Pre-specified subgroup analysis [Scirica 2012]

Vorapaxar for the secondary prevention of thrombotic events in patients with a recent MI

PEGASUS [Bonaca 2014]

Ticagrelor in patients with a history of MI and at least one additional thrombotic risk factor

Bhatt DL, et al. J Am Coll Cardiol 2007;49:1982–1988; Bhatt DL, et al. N Engl J Med 2006;354:1706–1717; Bonaca MP, et al. ; CAPRIE steering committee. Lancet 1996;348:1329–1339; Morrow DA, et al. N Engl J Med 2012;366:1404–1413; Scirica SM, et al. Lancet 2012;380:1317–1324

EVIDENCIAS DEL BENEFICIO A LARGO PLAZO

CAPRIE [CAPRIE steering committee 1996]

Clopidogrel en monoterapia reduce de forma significativa de muerte CV, IM ó ictus en pacientes con IM reciente, ictus ó EAP sintomática comparado con AAS con un seguimiento medio de 1.9 años

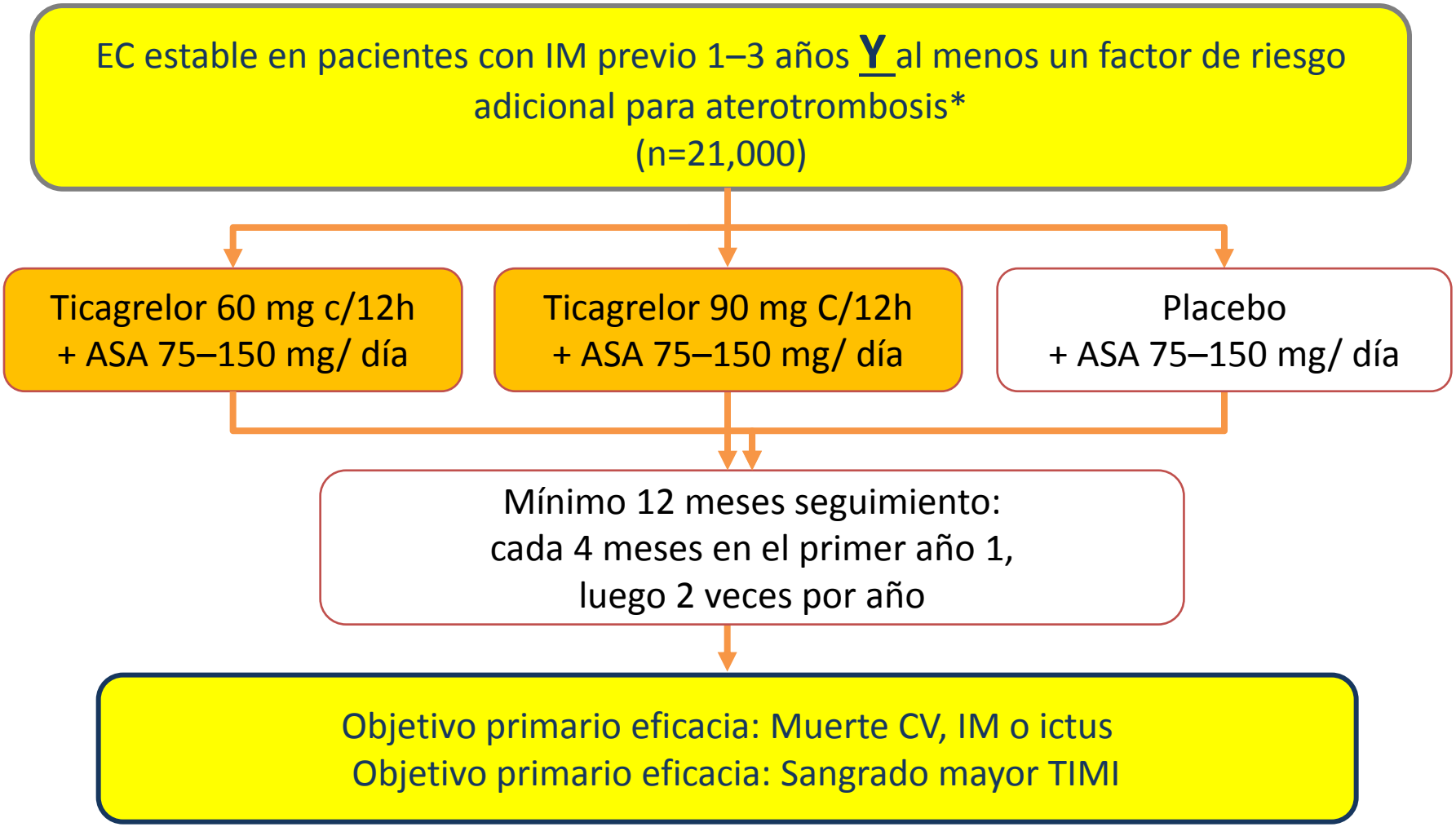
CHARISMA: Análisis subgrupos Post-hoc [Bhatt 2007]

Clopidogrel + ASA continua reduciendo riesgo de eventos CV más allá del año de tratamiento en pacientes con ECV sintomática

TRA2ºP-TIMI 50: Pre-specified subgroup analysis [Scirica 2012]

Vorapaxar añadido a ASA ± tienopiridina reduce el riesgo de eventos CV después de 3 años de tratamiento en pacientes con IM previo
Riesgo de sangrado aumentado pero beneficio clínico neto observado

PEGASUS TIMI-54



Bonaca MP, et al. Am Heart J 2014;In press

CARACTERÍSTICAS DE LOS PACIENTES

Qualifying event and CV history	Total study population (N=21,162)
Time from MI to randomisation, years Interquartile range	1.7 1–2
Qualifying event, %	
NSTEMI	41
STEMI	54
Type not specified	5
History %	
PCI	83
CABG	5
PAD	5
Qualifying risk factors, %	
Age ≥65 years	55
Diabetes mellitus requiring medication	28
Second prior MI	17
Multivessel coronary disease	59
Chronic renal dysfunction	6

Bonaca MP, et al. Am Heart J 2014;In press

DAPT PCI Duración

BMS PCI

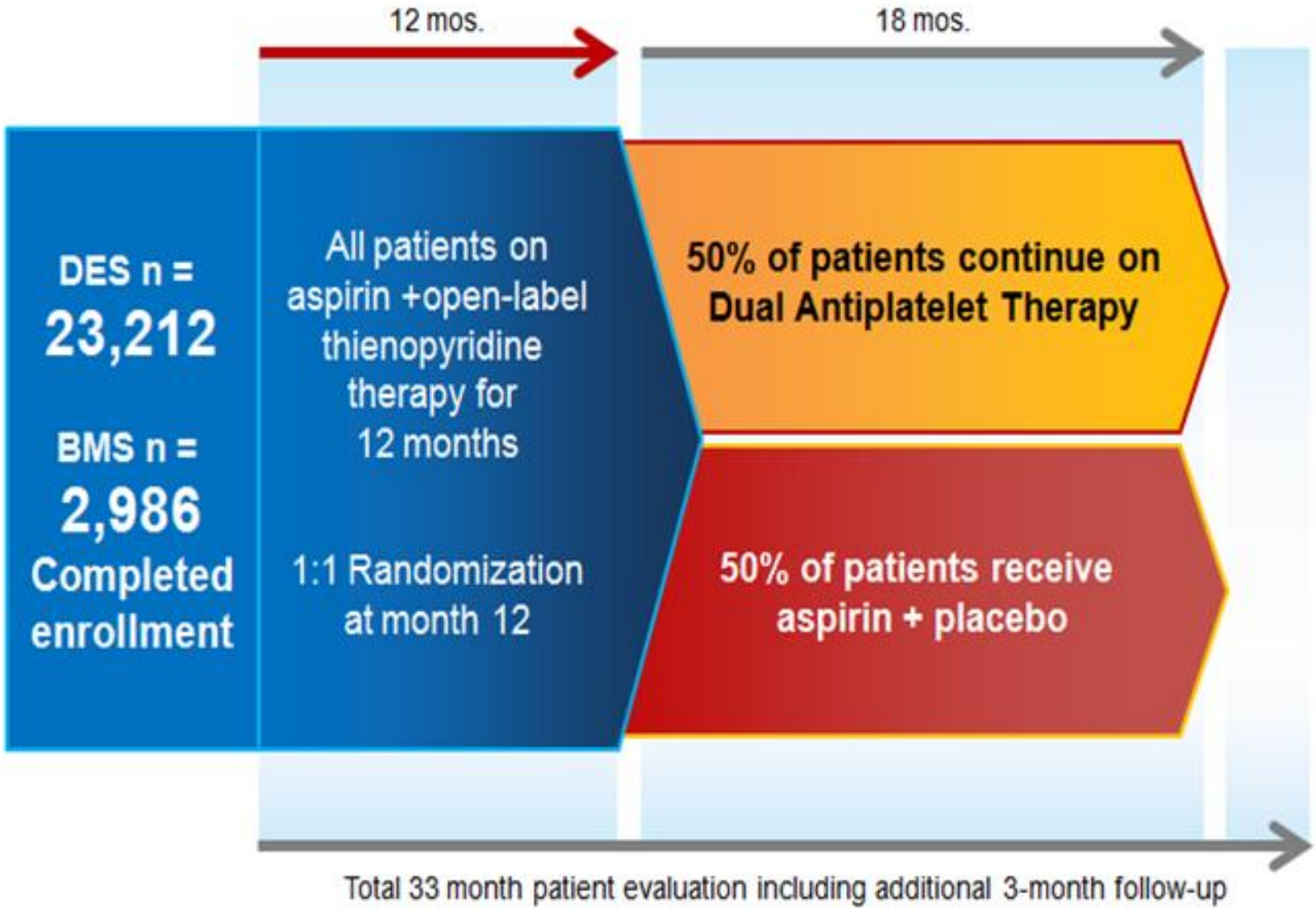
1mes recomendado,
Mínimo 2 semanas si
necesidad urgente de parar

DES PCI

12 meses recomendado
Mínimo 3-6 si necesidad
urgente de parar

12 meses para BMS o DES en SCA

DAPT PCI Duración



GLOBAL LEADERS

GLOBAL LEADERS: A Clinical Study Comparing Two Forms of Anti-platelet Therapy After Stent Implantation

Comparative Effectiveness of 1 Month of Ticagrelor Plus Aspirin Followed by Ticagrelor Monotherapy Versus a Current-day Intensive Dual Antiplatelet Therapy in All-comers Patients Undergoing Percutaneous Coronary Intervention With Bivalirudin and BioMatrix Family Drug-eluting Stent Use

16.000 PACIENTES

ASA+TICAGRELOR 1 mes+ TICAGRELOR 23 meses

ASA+TICAGRELOR 12 meses +ASA 12 meses

ASA+CLOPIDOGREL 12 meses +ASA 12 meses

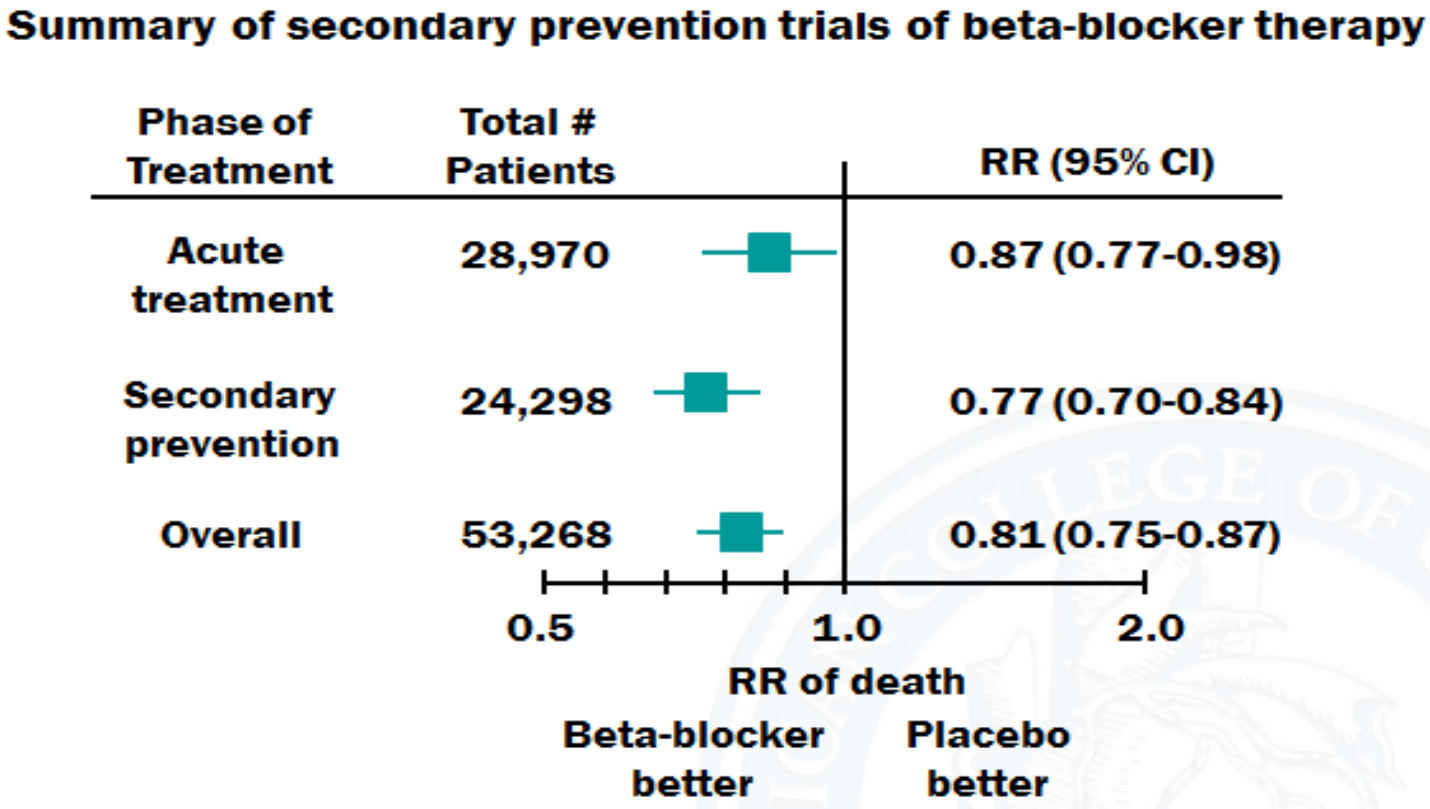
PRIMERA VEZ QUE SE PRESCINDE DE ASPIRINA Y SE UTILIZA TICAGRELOR A LARGO PLAZO 23 meses EN UN GRUPO DE PACIENTES SOMETIDOS a PCI

EVIDENCIAS CON BETABLOQUEANTES

Placebo-controlled post-MI trials* using oral beta-blockers

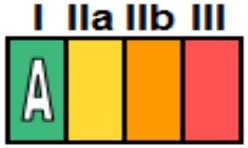
Study	Patients (N)	Treatment Groups	Duration of Follow-Up	Effect on Mortality	Effect on Reinfarction
Göteborg Study†	1,395	Metoprolol tartrate	3 months	↓ 36% (*P*<.03)	*P*=NS
Timolol Trial (Norwegian)	1,884	Timolol	17 months	↓ 39% (*P*=.003)	↓ 28% (*P*=.0005)
Lopressor Intervention Trial	2,395	Metoprolol tartrate	12 months	*P*=NS	NA
Beta-blocker Heart Attack Trial	3,837	Propranolol	25 months	↓ 26% (*P*<.005)	*P*=NS
CAPRICORN Trial	1,959	Carvedilol	15 months	↓ 23% (*P*=.03)	↓ 40% (*P*=.01)

BETABLOQUEANTES EN PREVENCIÓN SECUNDARIA



Antman E, Braunwald E. Acute Myocardial Infarction. In: Braunwald E, Zipes DP, Libby P, eds. Heart Disease: A textbook of Cardiovascular Medicine, 6th ed., Philadelphia, PA: W.B. Sanders, 2001, 1168

BETABLOQUEANTES EN PREVENCIÓN SECUNDARIA



FEVI≤ 40% con IM previo o IC

Beta-blocker should be used in all patients with LVSD (ejection fraction ≤40%) with HF or prior MI, unless contraindicated*. (Use should be limited to carvedilol, metoprolol succinate, or bisoprolol, which have been shown to reduce mortality.)

Duración 3 años

Beta-blocker for 3 years in all patients with normal left ventricular function who have had a MI or ACS

> 3 años con FEVI normal en SCA o IAM

Beta-blocker beyond 3 years as chronic therapy in all patients with normal left ventricular function who have had a MI or ACS

*Relative contraindications include asthma, chronic obstructive pulmonary disease, insulin dependent diabetes mellitus, severe peripheral arterial disease, and a PR interval >0.24 seconds

Disfunción VI sin IM o IC

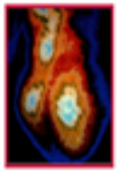
Beta-blocker in patients with LVSD (ejection fraction ≤40%) without HF or prior MI

Para todos los pacientes coronario ó con enfermedad vascular

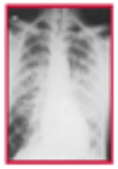
Beta-blocker as chronic therapy for all other patients with coronary or other vascular disease

Smith SC Jr. et al. JACC 2011;58:2432-2446

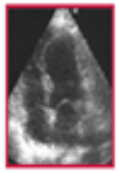
IECAs



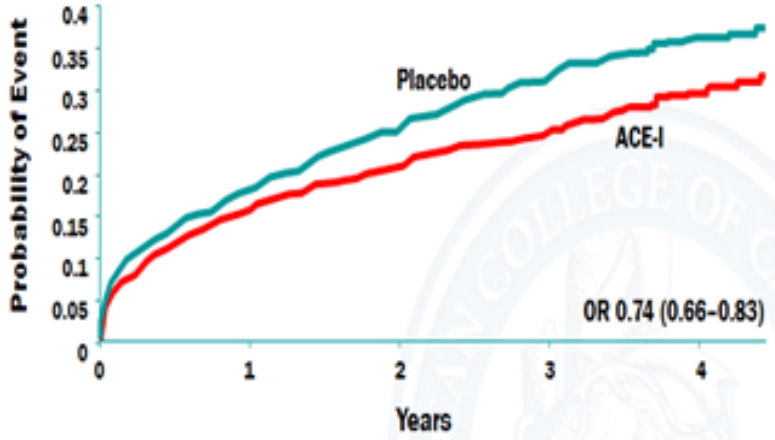
SAVE
Radionuclide
EF ≤40%



AIRE
Clinical and/or radiographic signs of HF



TRACE
Echocardiogram
EF ≤35%



An ACE-I provides substantial benefit in post-MI LVSD

Flather MD et al. Lancet 2000;355:1575–1581

Meta-Analysis of the HOPE, EUROPA, and PEACE Trials*

Clinical Trial	N	Deaths	RR of Mortality
HOPE	9,297	1051	HR=0.84 P=0.005
EUROPA	12,218	795	HR=0.89 P=0.10
PEACE	8,290	633	HR=0.89 P=0.13
All Trials	33,960	>3000	HR=0.86 P<0.001

Danchin N et al. Arch Intern Med 2006;166:787-796
The HOPE Trial Investigators. NEJM 2000;342:145-153
The EUROPA Study. Lancet 2003; 362: 782-788
The PEACE Trial Investigators. NEJM 2004;351:2058-2068

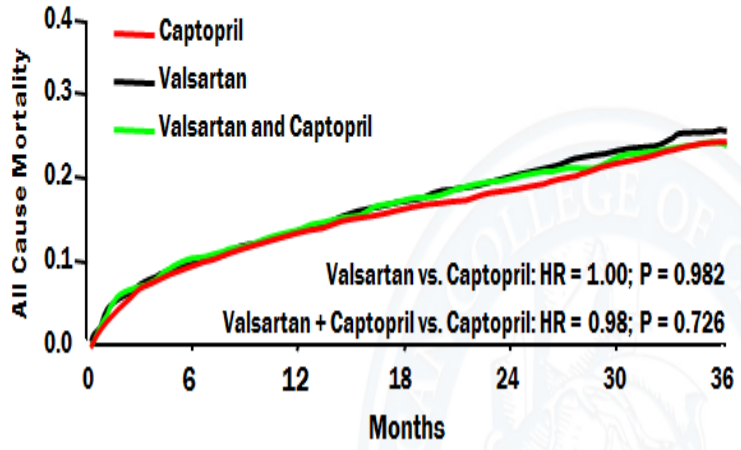
An ACE inhibitor should be started and continued indefinitely in all patients with left ventricular ejection fraction ≤40% and in those with hypertension, DM, or CKD, unless contraindicated

An ACE inhibitor in all other patients

ARA2

Valsartan in Acute Myocardial Infarction Trial (VALIANT)

14,703 patients with post-MI HF or LVSD (EF <0.40) randomized to captopril (50 mg tid), valsartan (160 mg bid), or captopril (50 mg tid) plus valsartan (80 mg bid) for 2 years

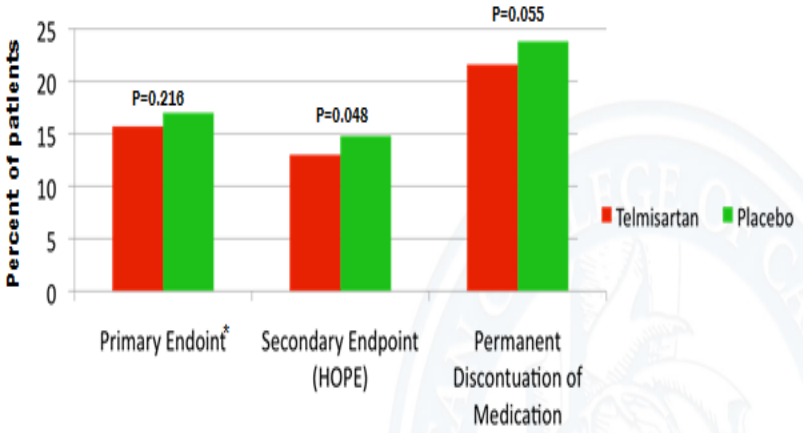


An ARB provides similar efficacy to an ACE inhibitor in Post-MI LVSD

Pfeffer M et al. NEJM 2003;349:1893-1906

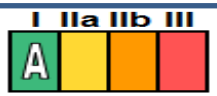
Telmisartan Randomized Assessment Study in ACE Intolerant Subjects with Cardiovascular Disease (TRANSCEND)

5,926 high risk patients intolerant to ACE inhibitors randomized to telmisartan (80 mg) or placebo for 56 months



An ARB is well tolerated in those unable to take an ACE inhibitor

TRANSCEND Investigators. Lancet. 2008;372:1174-83



An ARB in patients who have HF or who have had a MI with left ventricular ejection fraction ≤40% and who are ACE-inhibitor intolerant

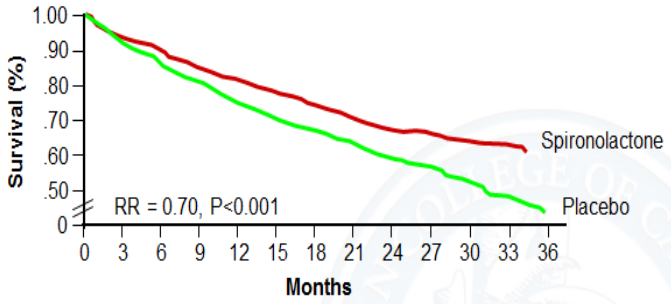
An ARB in other patients who are intolerant of an ACE inhibitor

Use of an ARB in combination with an ACE inhibitor is not well established in those with systolic heart failure

ARM

Randomized Aldactone Evaluation Study (RALES)

1,663 patients with NYHA Class III or IV HF and LVSD (EF <0.35) randomized to spironolactone (25-50mg) or placebo for 24 months

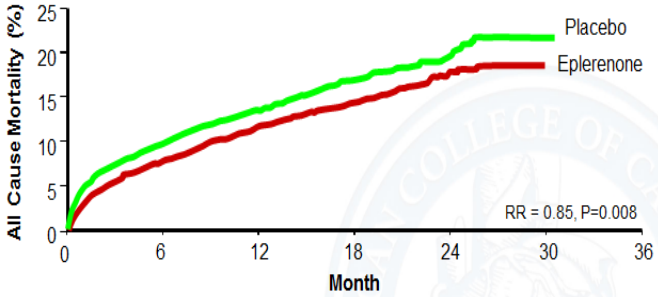


Aldosterone inhibition improves survival in patients with advanced heart failure

Pitt B et al. NEJM 1999;341:709-717

Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival Study (EPHESUS)

3,313 patients with evidence of HF and LVSD (EF <0.40) after a MI randomized to eplerenone (25-50 mg) or placebo for 16 months

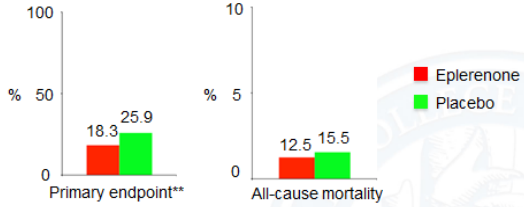


Aldosterone inhibition improves survival in patients with post-MI HF and LVSD

Pitt B et al. NEJM 2003;348:1309-1321

Eplerenone in Mild Patients Hospitalization and Survival Study in Heart Failure (EMPHASIS-HF)

2737 patients with NYHA Class II HF symptoms and LVSD (mean LV EF 26%) randomized to eplerenone (25-50 mg) or placebo for a median of 21 months*

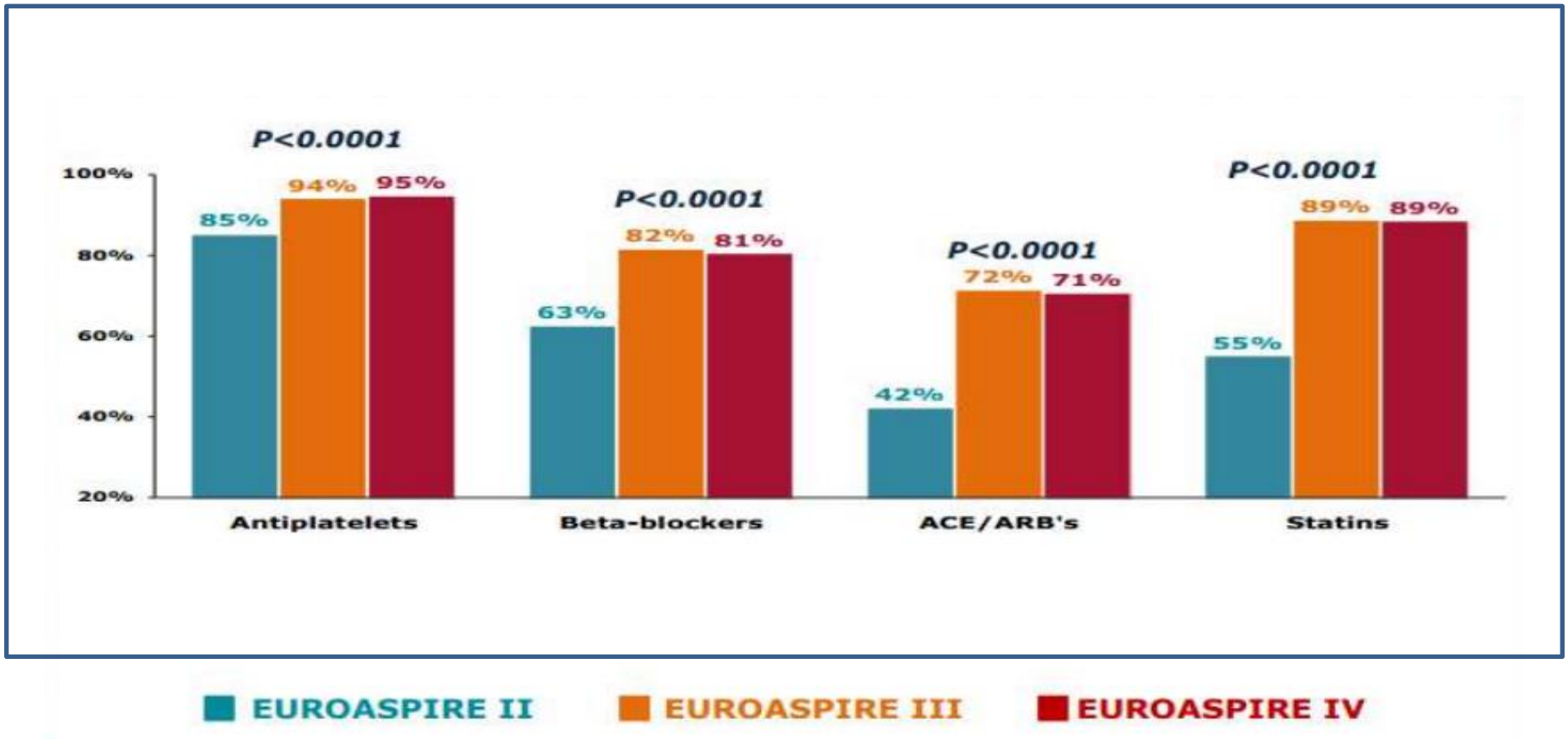


Aldosterone inhibition improves survival in patients with mild HF and LVSD

Zannad F et al. NEJM 2011;364:11-21

Use of aldosterone blockade in post-MI patients without significant renal dysfunction* or hyperkalemia** is recommended in patients who are already receiving therapeutic doses of an ACE inhibitor and beta-blocker, who have a LV EF ≤40%, and who have either DM or HF

PRESCRIPCIÓN DE FÁRMACOS



PRIORIDAD 3

TITULACIÓN y ADHERENCIA/ANTIAGREGANTES INDICADOS EN LAS GUÍAS/FRECUENCIA CARDIACA

COLESTEROL-ESTATINAS

OBJETIVO guías AHA/ACC **2011**

Tratamiento con estatinas para alcanzar LDL-c de 100 mg/dL; muy alto riesgo LDL-C≤70 mg/dL es razonable; si TG > 200 mg/dL, C no-HDL debería ser 130 mg/dL, mientras que C no-HDL 100 mg/dL para muy alto riesgo

Circulation 2011

Guías Europeas Prevención 2012

Clasificación de riesgo	Tipo de pacientes	LDL-C
MUY ALTO RIESGO	ECV documentada (CI, ictus, EAP) DM(tipo 1 ó 2) con 1 ó más FRCV y/o lesión subclínica, MAU IRC severa(FG <30 ml/min/1.73m2 SCORE≥ 10	70 mg/dl
ALTO RIESGO	1 FRCV muy elevado(Dislipemia Familiar) HTA severa DM tipo 1 ó 2 sin FRCV ó lesión subclínica IRC moderada (FG 30-59 ml/min/1.73m2) SCORE≥ 5% y < 10%	100 mg/dl

EHJ 2012

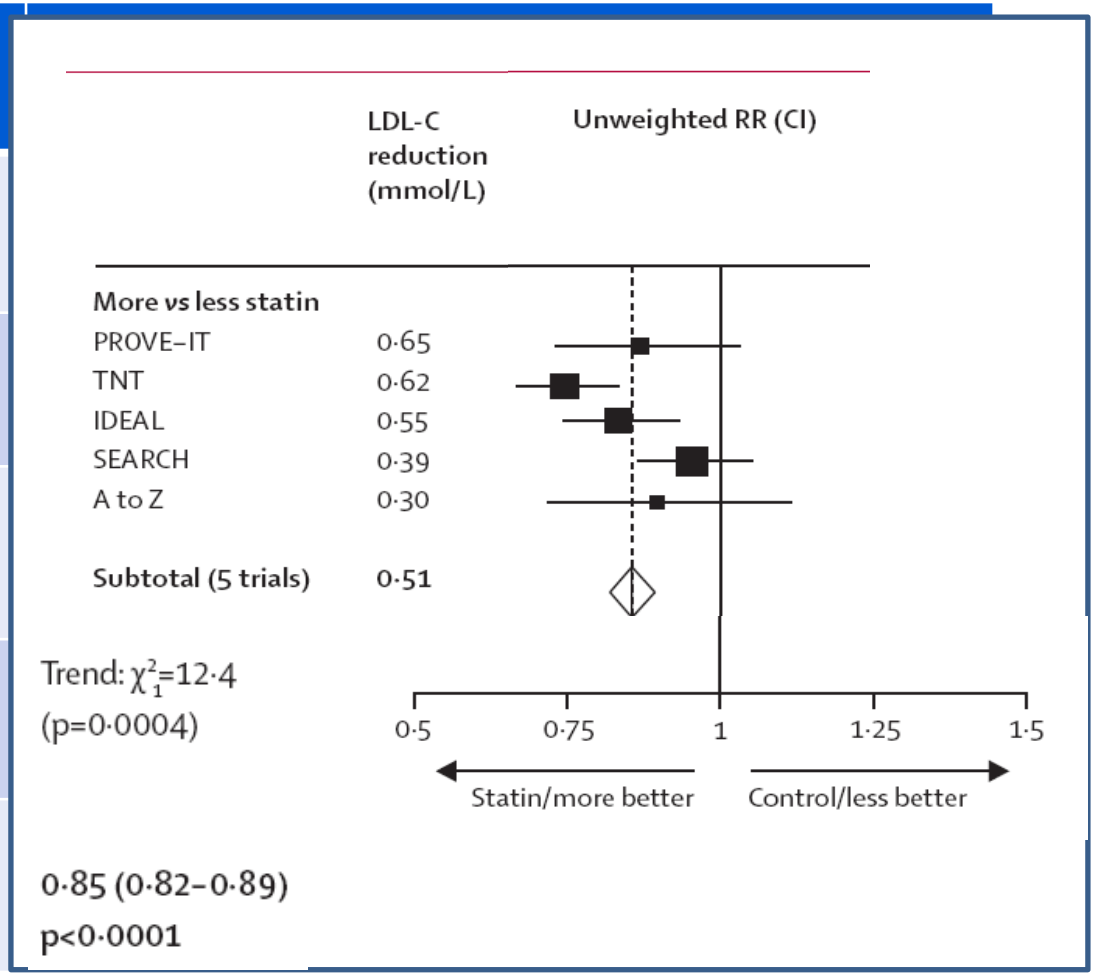
REDUCCIÓN LDL-C ESTATINAS

Simvastatina	Atorvastarina	Pitavastatina	Rosuvastatina	%↓ LDL-C
10 mg				30%
20 mg	10 mg	1 mg		38%
40 mg	20 mg	2 mg	5 mg	41%
	30 mg	4 mg		44%
	40 mg		10 mg	47%
	60 mg			51%
	80 mg		20 mg	55%
			40 mg	60%

Nicholls SJ et al. Am J Cardiol. 2010 Jan 1;105(1):69-76; Eur. Heart J. 2001(Suppl) 3:E17-E23

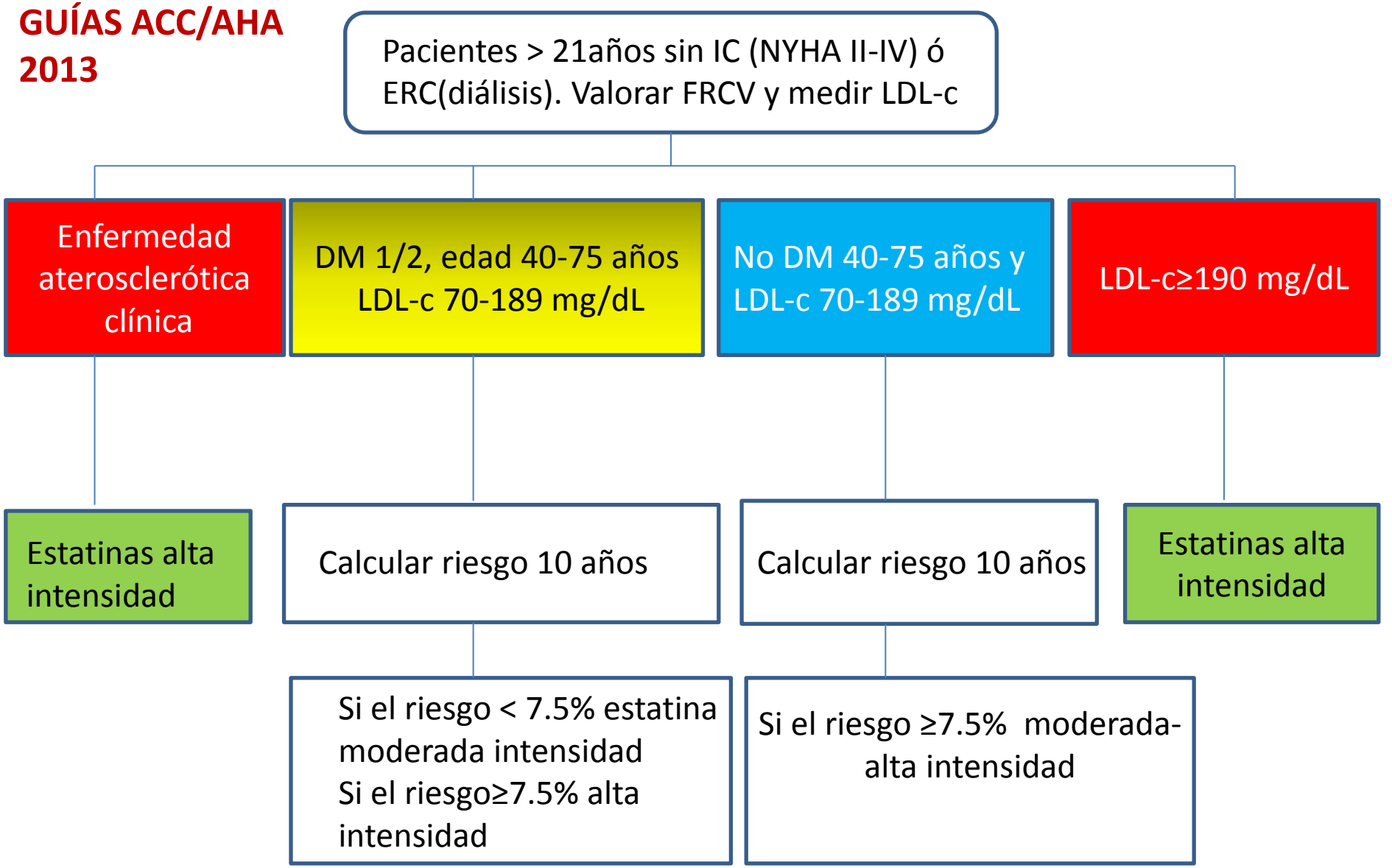
TRATAMIENTO INTENSIVO CON ESTATINAS

ENSAYO		Control Intensivo
PROVE–IT	NEJM 2004	P 40 A 80
TNT	NEJM 2005	A10 A 80
IDEAL	JAMA 2005	S20-40 A40-80
SEARCH	Lancet 2010	S20 S80
A to Z	JAMA 2004	Pla-S20 S40-80



Josan K et al CMAJ. 2008 Feb 26;178(5):576-84

GUÍAS ACC/AHA 2013



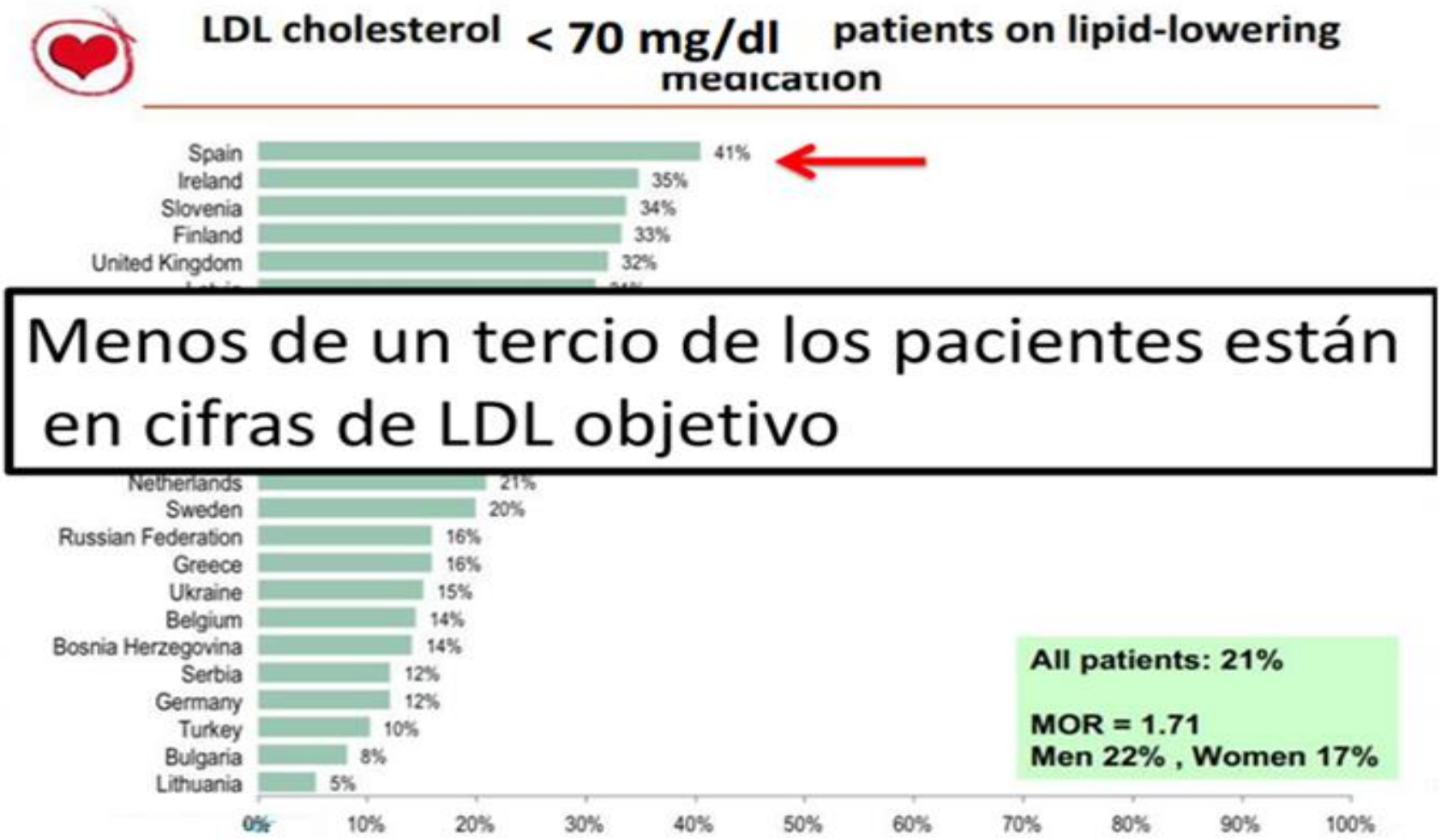
Modificado de N Engl J Med 370;3 nejm.org january 16, 2014

ESTATINAS: ALTA-MODERADA-BAJA INTENSIDAD

High-Intensity Statin Therapy	Moderate-Intensity Statin Therapy	Low-Intensity Statin Therapy
Daily dose lowers LDL–C on average, by approximately ≥50%	Daily dose lowers LDL–C on average, by approximately 30% to <50%	Daily dose lowers LDL–C on average, by <30%
Atorvastatin (40†)–80 mg **Rosuvastatin 20 *(40)* mg**	**Atorvastatin 10 *(20)* mg** **Rosuvastatin *(5)* 10 mg** **Simvastatin 20–40 mg‡** **Pravastatin 40 *(80)* mg** **Lovastatin 40 mg** *Fluvastatin XL 80 mg* **Fluvastatin 40 mg bid** *Pitavastatin 2–4 mg*	*Simvastatin 10 mg* **Pravastatin 10–20 mg** **Lovastatin 20 mg** *Fluvastatin 20–40 mg* *Pitavastatin 1 mg*

Stone NJ et al JACC 2013

LDL-COLESTEROL



Menos de un tercio de los pacientes están en cifras de LDL objetivo

PRIORIDAD 4

PRESIÓN ARTERIAL

2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults
Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)

OBJETIVO : 140/90 mm Hg

Clase I

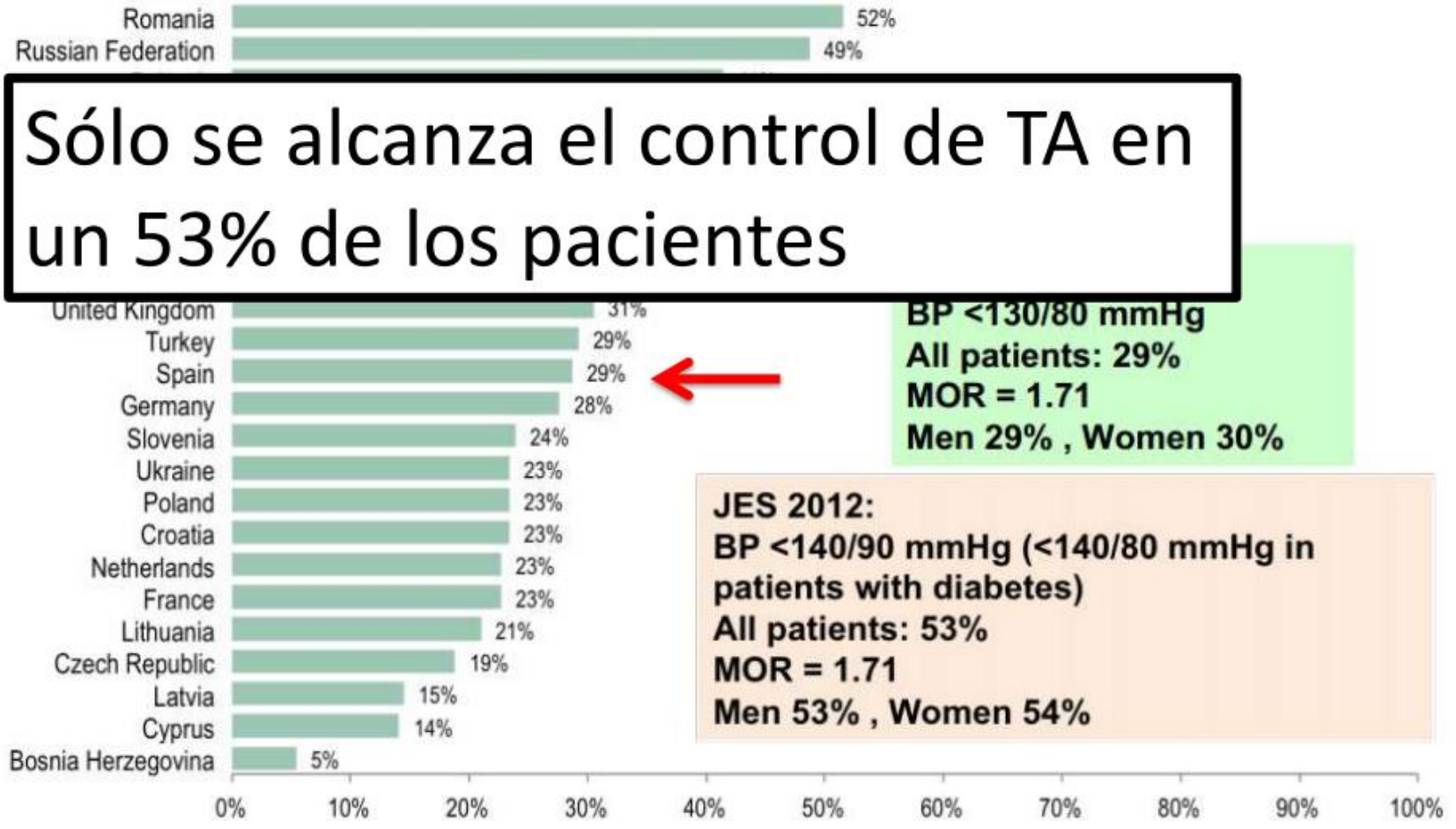
1. Todos los pacientes deben ser aconsejados para modificar el estilo de vida; control del peso, incremento de la actividad física, moderación con el alcohol, reducción ingesta de sodio y consumos de fruta, vegetales y alimentos diarios bajos en grasas (B)

2. Pacientes con PA >140/90 mm Hg deben ser tratados con antihipertensivos , betabloquentes y/o IECAs, añadiendo otros fármacos para alcanzar los objetivos de PA (A)

JAMA. doi:10.1001/jama.2013.284427

HTA

Therapeutic control of blood pressure *



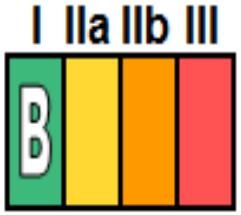
Sólo se alcanza el control de TA en un 53% de los pacientes

BP <130/80 mmHg
All patients: 29%
MOR = 1.71
Men 29% , Women 30%

JES 2012:
BP <140/90 mmHg (<140/80 mmHg in patients with diabetes)
All patients: 53%
MOR = 1.71
Men 53% , Women 54%

PRIORIDAD 5

VACUNA INFLUENZA



Patients with cardiovascular disease should have an annual influenza vaccination

NO OLVIDAR

Smith Jr SC et al. JACC 2011;58:2432-2446

PRIORIDADES OLVIDADAS SCA

Risk factor modification/ lifestyle interventions

- **Smoking cessation**

Medications
- Antithrombotic therapies
- Beta blockers
- ACE inhibitors /ARBs /MRA
- Statins

Psychosocial factors
- Sexual activity
- Gender-specific issues
- **Depression, stress, and anxiety**
- Alcohol use
- Culturally sensitive issues

Provider follow -up
- Cardiologist
- Primary care provider
- Advanced practice nurse/ physician
- Other relevant medical specialists
- Electronic personal health records

Management of comorbidities
- Overweight/ obesity
- **Lipids**
- **Hypertension**
- **Diabetes**
- HF
- Arrhythmia/ arrhythmia risk

30% RE-SCA

Patient /Family education
- Plan of care for acute MI
- Recognizing symptoms of MI
- Activating EMS, signs and symptoms for urgent vs emergency evaluations
- CPR training for family members

Frecuencia cardiaca

- **Influenza vaccination**

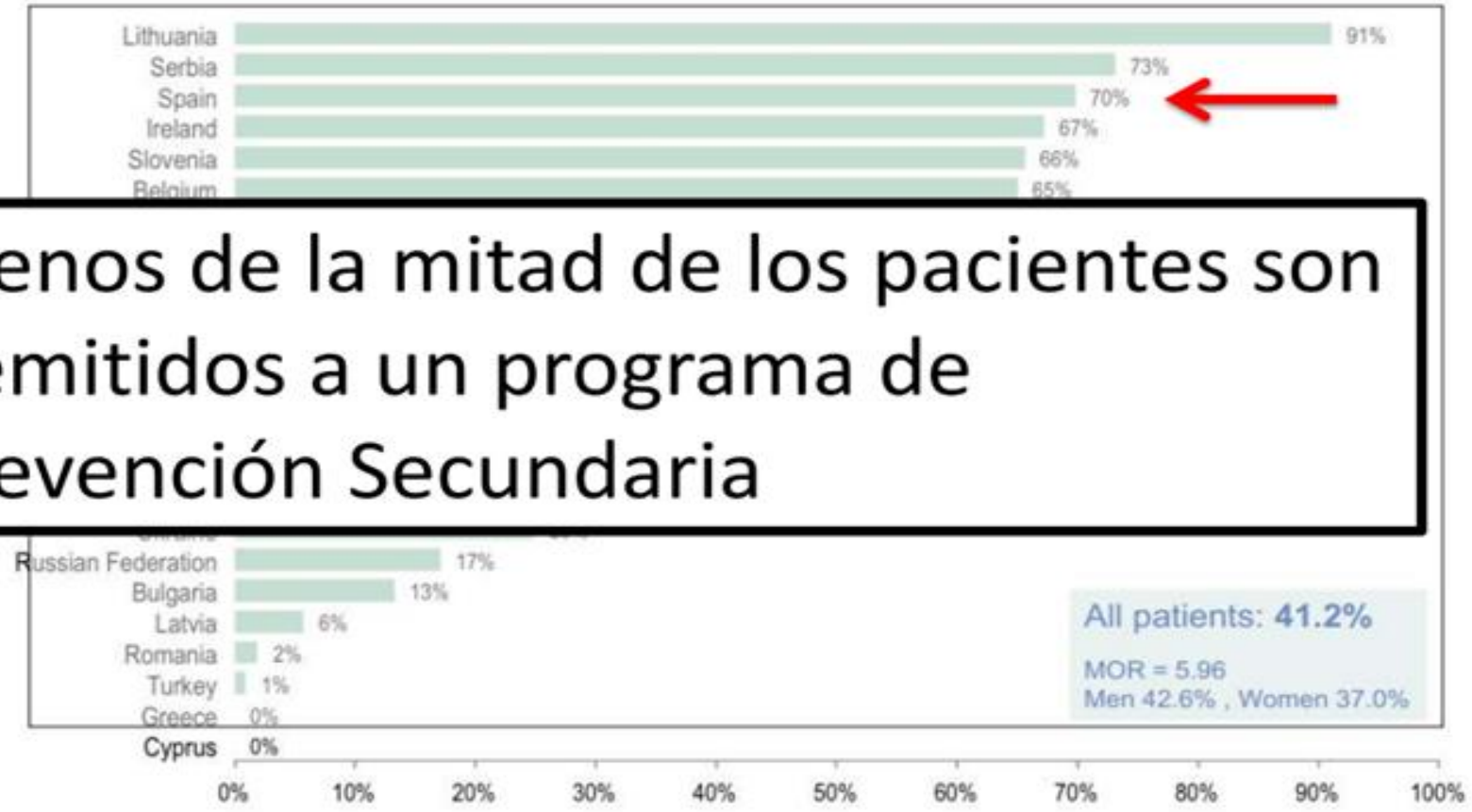
JACC 2013

PROGRAMAS DE REHABILITACIÓN CARDIACA

EUROASPIRE IV

Attendance to CPR programme among all patients*

Interview



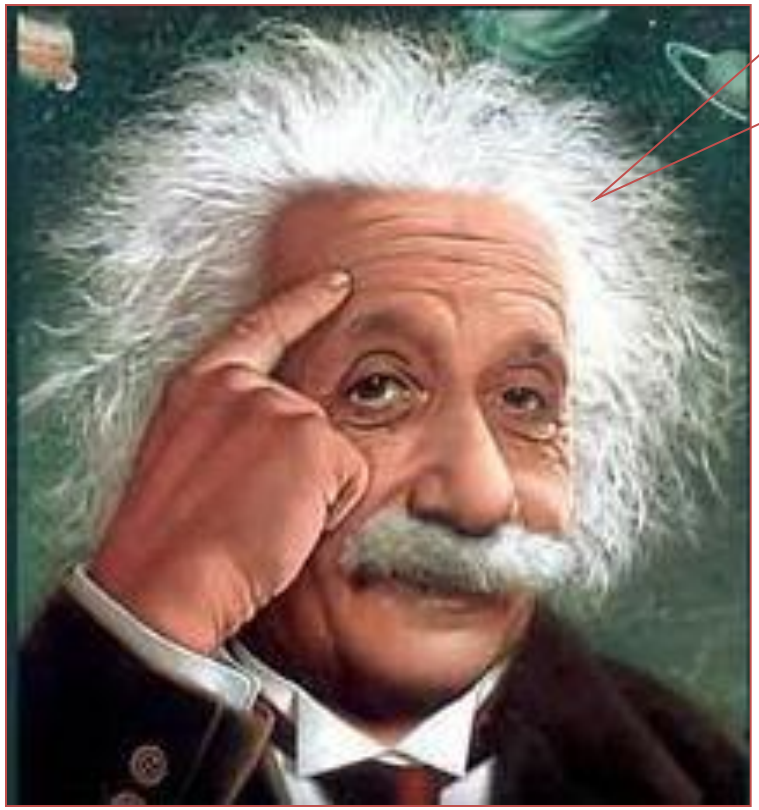
Menos de la mitad de los pacientes son remitidos a un programa de Prevención Secundaria

PRIORIDAD MÁXIMA

MUCHAS GRACIAS POR VUESTRA ATENCIÓN

Si buscas resultados distintos,

No hagas siempre lo mismo



Albert Einstein