SINDROME CORONARICA ACUTA: Strategia conservativa vs invasiva

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Clinical Frailty Scale

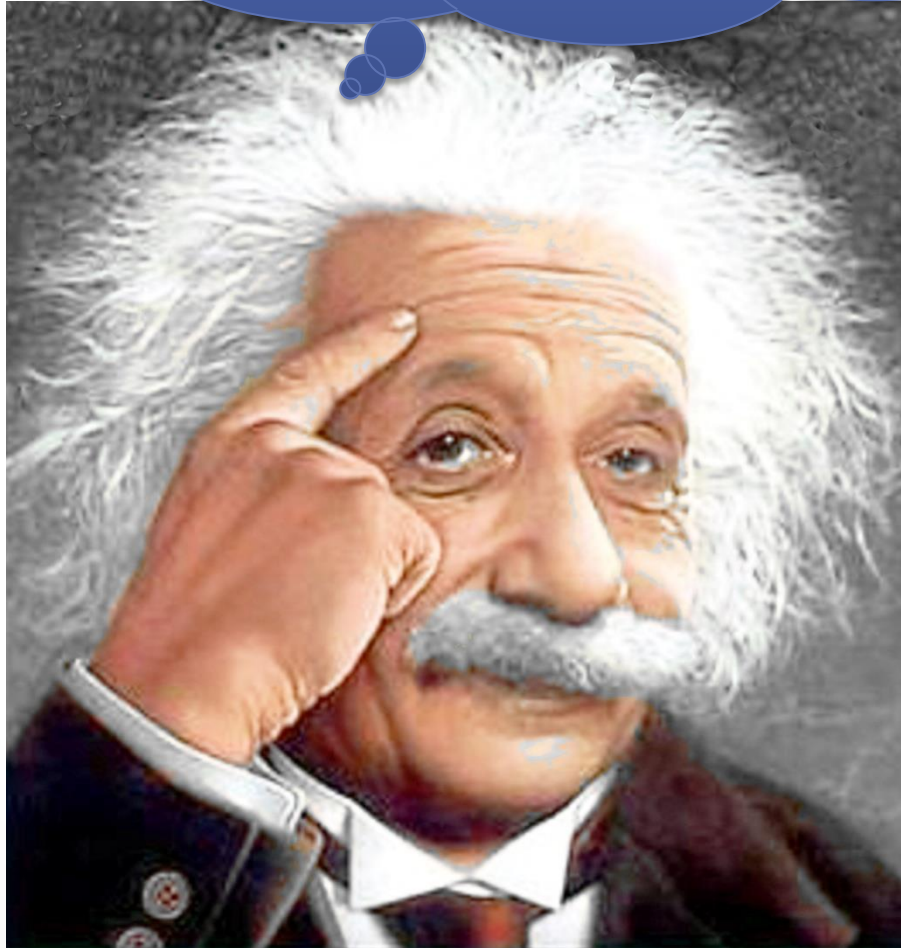**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
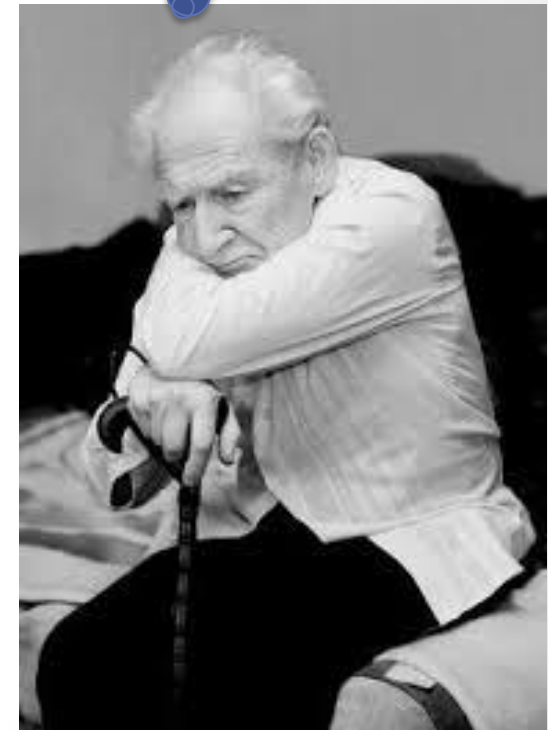
9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

ESC GUIDELINES

Recommendations for the management of elderly patients with non-ST-elevation acute coronary syndromes

2015 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Task Force for the Management of Acute Coronary Syndromes in Patients Presenting without Persistent ST-Segment Elevation of the European Society of Cardiology (ESC)

Recommendations	Class[a]	Level[b]	Ref.[c]
It is recommended to tailor antithrombotic treatment according to bodyweight and renal function.	I	C	
Elderly patients should be considered for an invasive strategy and, if appropriate, revascularization after careful evaluation of potential risks and benefits, estimated life expectancy, comorbidities, quality of life, frailty and patient values and preferences.	IIa	A	408, 414–418
Adjusted... beta-blo... and stat... prevent...			

ACE = ang...
NSTE-ACS = non-ST-elevation acute coronary syndromes.
[a]Class of recommendation.
[b]Level of evidence.
[c]References supporting level of evidence.

Pz >75 aa con NSTEMI

1005 pz -> PCI
931 pz -> no PCI

Clinical research
Interventional cardiology

...y on in-hospital outcome
...ST-elevation

...eer, Harm Wienbergen, Anselm Gitt, Ralf Zahn,
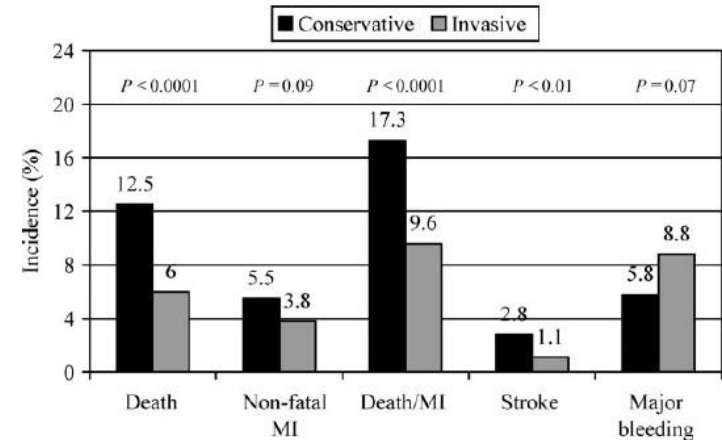...oronary Syndromes Registry (ACOS) Investigators

Figure 1 Hospital complications in two groups with a conservative or invasive strategy in the univariate analysis.

Coronary Artery Disease

51827 pz >75 aa
5557 pz > 90 aa

Uso di:
aspirina
Beta-bloccanti
eparina entro 24h
early PCI

Adam H. Skolnick, MD,* Karen P. Al...
Matthew T. Roe, MD, MSH,† Charle...
John S. Rumsfeld, MD, PhD,§ W. Br...
David J. Cohen, MD, MSc*¶

Boston, Massachusetts; Durham, North Carolina; Philadelphia, Pennsylvania; Denver, Colorado;
Cincinnati, Ohio; and Kansas City, Missouri

CLINICAL RESEARCH
Coronary heart disease
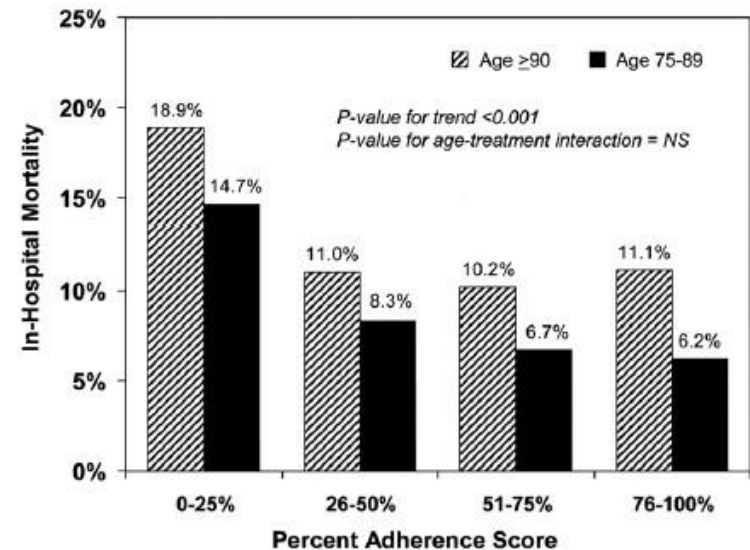
Management and 6-month outcomes in elderly and very elderly patients with high-risk non-ST-elevation acute coronary syndromes: The Global Registry of Acute Coronary Events

Gerard Devlin[1]*, Joel M. Gore[2], John Elliott[3], Namal Wijesinghe[1], Kim A. Eagle[4], Álvaro Avezum[5], Wei Huang[2], and David Brieger[6] for the GRACE Investigators

8086 pz > 70 aa

5057 pz -> 70-80 aa
3029 pz -> > 80 aa
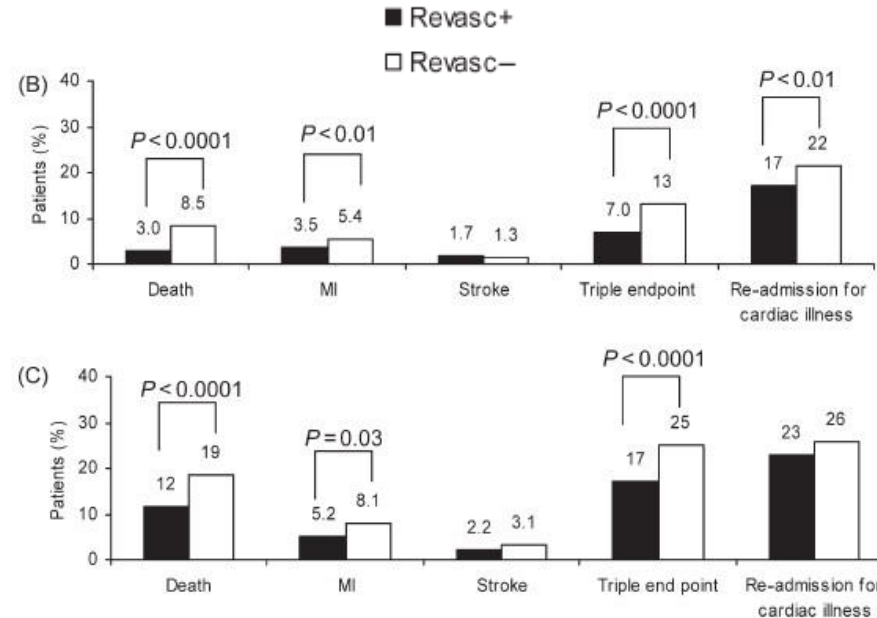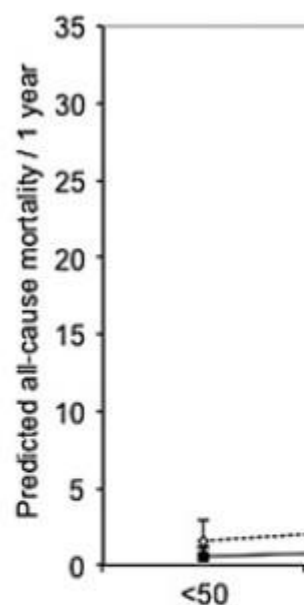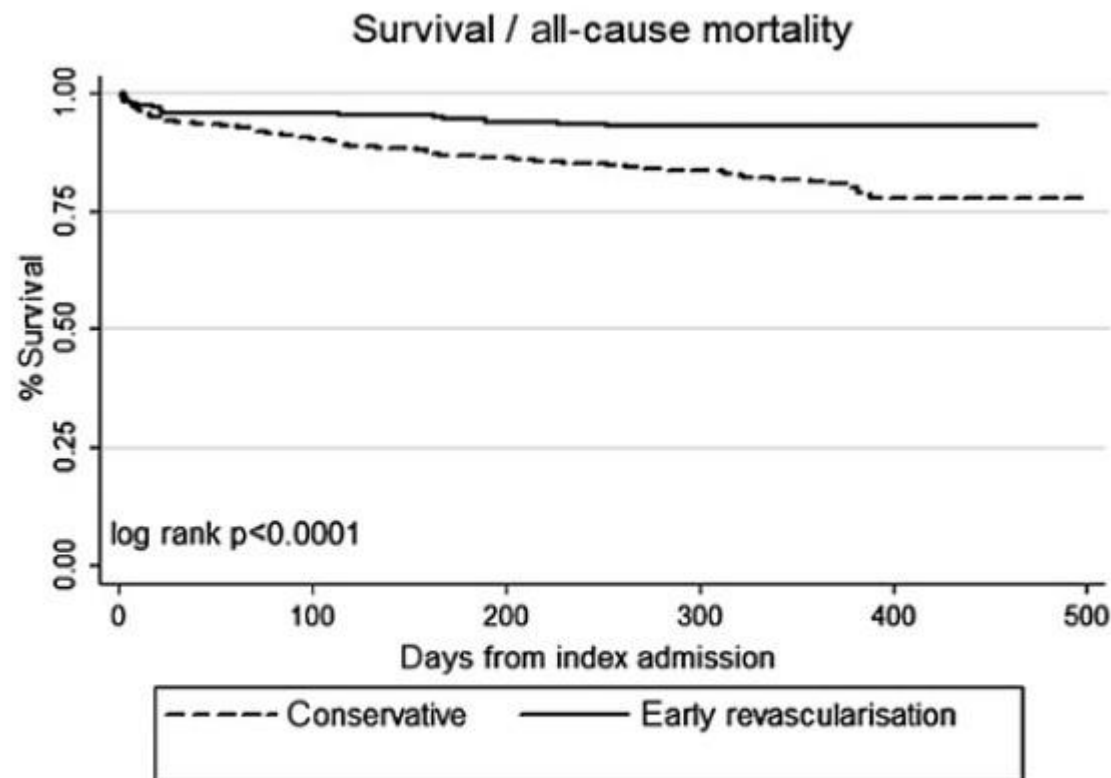
Figure 2   Survival curve of elderly acute coronary syndromes cohort with respect to early revascularisation.

MAYO CLINIC

ORIGINAL ARTICLE

Routine Invasive Versus Selective Invasive Strategy in Elderly Patients Older Than 75 Years With Non-ST-Segment Elevation Acute Coronary Syndrome: A Systematic Review and Meta-Analysis

Aakash Garg, MD; Lohit Garg, MD; Manyoo Agarwal, MD; Amit Rout, MD; Hitesh Raheja, MD; Sahil Agrawal, MD; Sunil V. Rao, MD; and Marc Cohen, MD

4 RCTs nelle analisi finali

1887 pz > 75 aa

● MAYO Clin Proc 2017

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End-point composito

Study or subgroup	Invasive Events	Total	Conservative Events	Total	Weight	Odds ratio M-H, random, 95% CI	Year
Italian elderly ACS	28	154	34	159	19.4%	0.82 [0.47, 1.43]	2012
FIR	109	437	135	402	67.2%	0.66 [0.49, 0.89]	2011
TACTICS-TIMI 18	15	139	30	139	13.4%	0.44 [0.22, 0.86]	2004
Total (95% CI)		730		700	100.0%	0.65 [0.51, 0.83]	
Total events	152		199				

Heterogeneity: Tau^2=0.00; Chi^2=1.96, df=2 (P=.38); I^2=0%
Test for overall effect: Z=3.44 (P=.0006)

Odds ratio M-H, random, 95% CI — Favors [invasive] / Favors [conservative]

Morte

Study or subgroup	Invasive Events	Total	Conservative Events	Total	Weight	Odds ratio M-H, random, 95% CI	Year
After eighty	57	229	62	228	60.3%	0.89 [0.58, 1.35]	2016
Italian elderly ACS	19	154	22	159	24.3%	0.88 [0.45, 1.69]	2012
TACTICS-TIMI 18	11	139	14	139	15.4%	0.77 [0.34, 1.75]	2004
Total (95% CI)		522		526	100.0%	0.87 [0.63, 1.20]	
Total events	87		98				

Heterogeneity: Tau^2=0.00; Chi^2=0.10, df=2 (P=.95); I^2=0%
Test for overall effect: Z=0.88 (P=.38)

Odds ratio M-H, random, 95% CI — Favors [invasive] / Favors [conservative]

Infarto

Study or subgroup	Invasive Events	Total	Conservative Events	Total	Weight	Odds ratio M-H, random, 95% CI	Year
After Eighty	39	229	69	228	32.2%	0.47 [0.30, 0.74]	2016
Italian elderly ACS	11	154	17	159	10.2%	0.64 [0.29, 1.42]	2012
FIR	62	437	92	402	50.6%	0.56 [0.39, 0.79]	2011
TACTICS-TIMI 18	6	139	19	139	7.1%	0.28 [0.11, 0.74]	2004
Total (95% CI)		959		928	100.0%	0.51 [0.40, 0.66]	
Total events	118		197				

Heterogeneity: Tau^2=0.00; Chi^2=2.12, df=3 (P=.55); I^2=0%
Test for overall effect: Z=5.20 (P<.00001)

Odds ratio M-H, random, 95% CI — Favors [invasive] / Favors [conservative]

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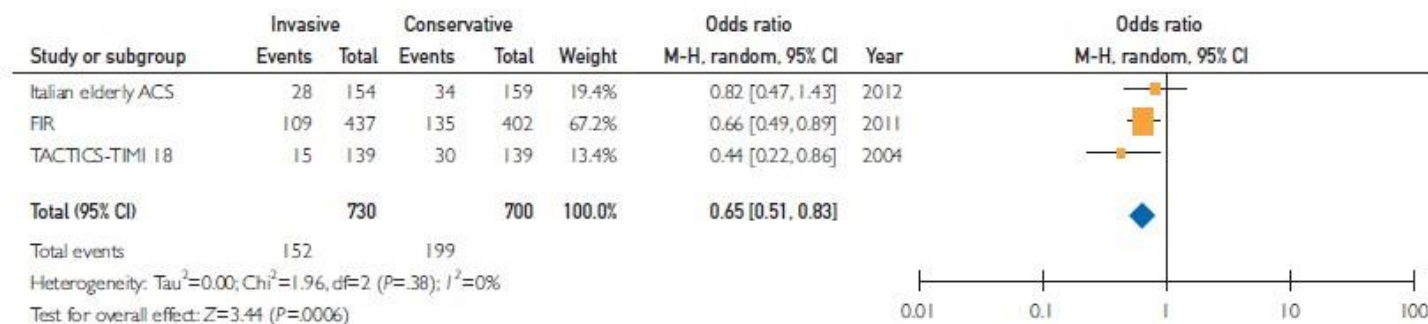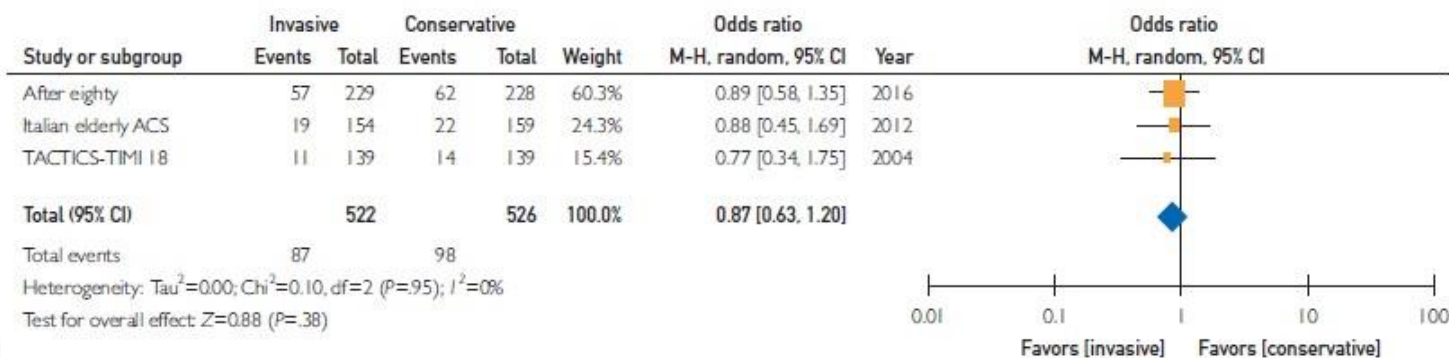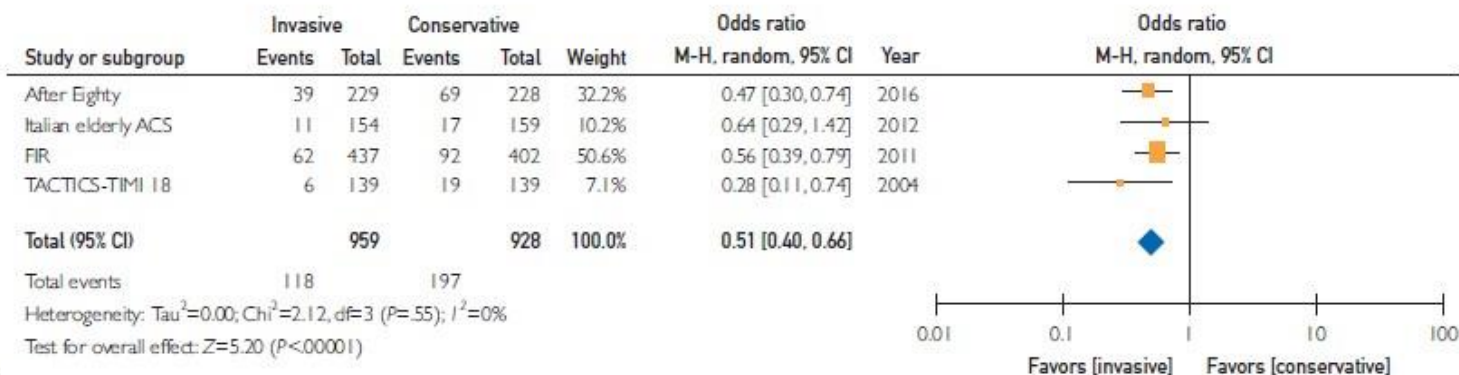MAYO CLINIC

ORIGINAL ARTICLE

Routine Invasive Versus Selective Invasive Strategy in Elderly Patients Older Than 75 Years With Non-ST-Segment Elevation Acute Coronary Syndrome: A Systematic Review and Meta-Analysis

…. data from our meta-analysis suggest that routine invasive strategy is a safe and effective strategy for NSTE-ACS even among very elderly patients.

….. physicians should also have an increased awareness of bleeding risk among such patients, but continued advances in PCI techniques as well as antithrombotic use would reduce procedural and bleeding complications
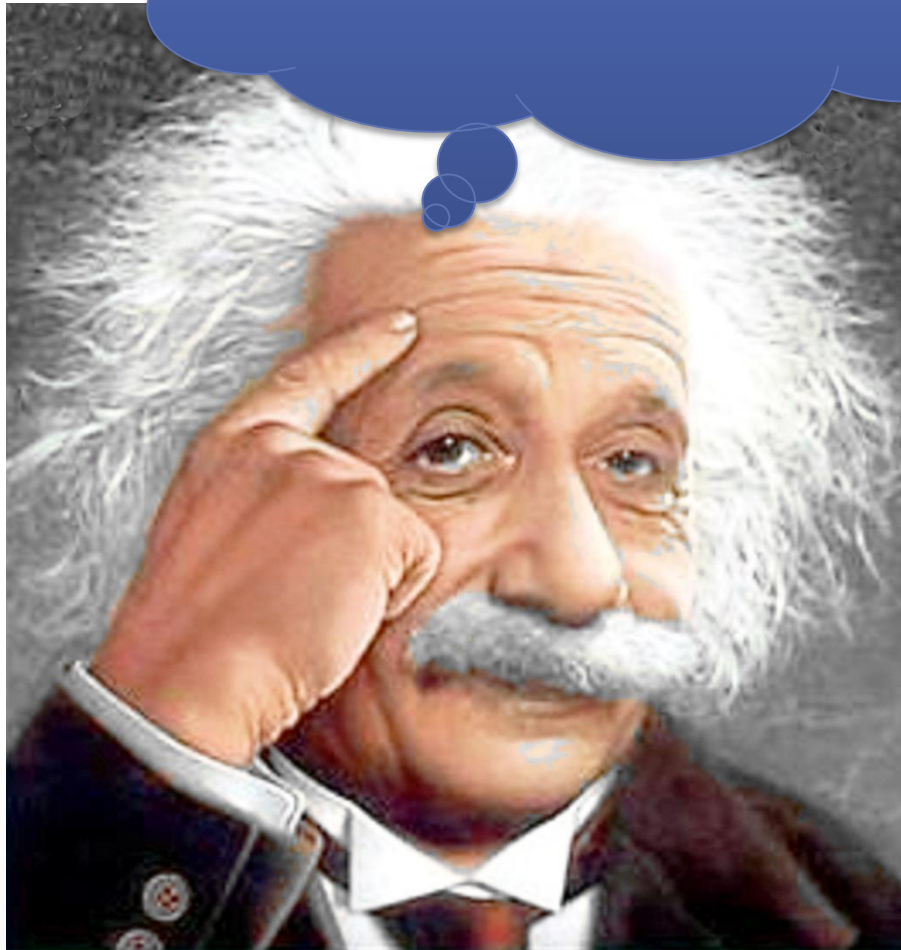
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ESC GUIDELINES

2015 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Task Force for the Management of Acute Coronary Syndromes in Patients Presenting without Persistent ST-Segment Elevation of the European Society of Cardiology (ESC)

Recommendations for the management of elderly patients with non-ST-elevation acute coronary syndromes

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ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker;
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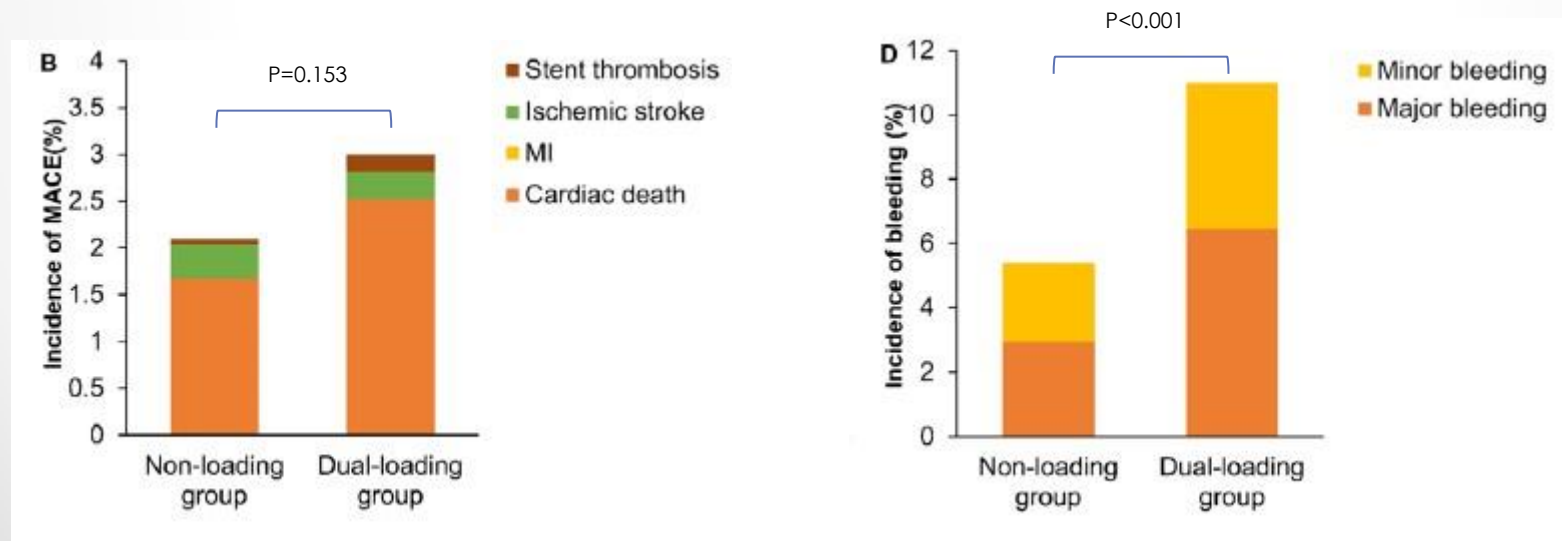[c]References supporting level of evidence.

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ORIGINAL RESEARCH

Non-loading group = 3293 pz
Loading group = 1897 pz

American Heart Association | American Stroke Association.

In-Hospital Outcomes of Dual Loading Antiplatelet Therapy in Patients 75 Years and Older With Acute Coronary Syndrome Undergoing Percutaneous Coronary Intervention: Findings From the CCC-ACS (Improving Care for Cardiovascular Disease in China-Acute Coronary Syndrome) Project

Guanqi Zhao, MD; Mengge Zhou, PhD; Changsheng Ma, MD; Yong Huo, MD; Sidney C. Smith Jr MD; Gregg C. Fonarow, MD; Junbo Ge, MD, PhD; Yaling Han, MD, PhD; Jing Liu, MD, PhD; Yongchen Hao, PhD; Jun Liu, MD; Xiao Wang, MD; Kathryn A. Taubert, PhD; Louise Morgan, MSN; Dong Zhao, MD, PhD; Shaoping Nie, MD, PhD; on behalf of the CCC-ACS Investigators*
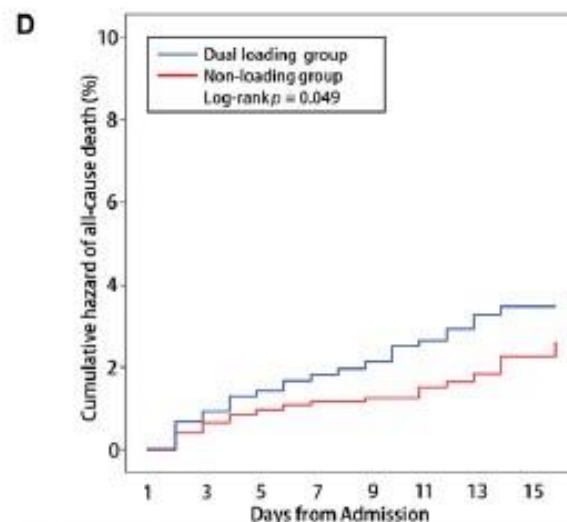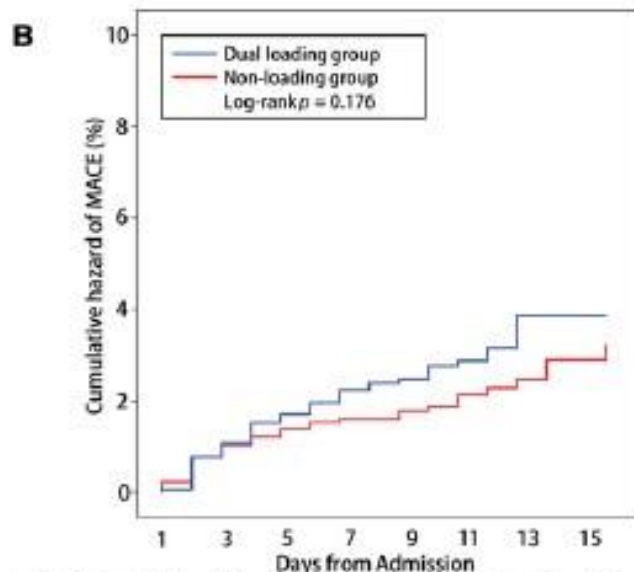
Matched group = 1642 pz

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ORIGINAL RESEARCH

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…. a dual loading dose of antiplatelet drugs within 24 hours of first medical contact were associated with increased risk of major bleeding but not with decreased risk of MACE among patients 75 years and older with ACS undergoing PCI.

….. clinicians should be cautious about administering a dual loading dose of antiplatelet therapy to patients 75 years and older with ACS undergoing PCI.

ESC GUIDELINES

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Recommendations for the management of elderly patients with non-ST-elevation acute coronary syndromes

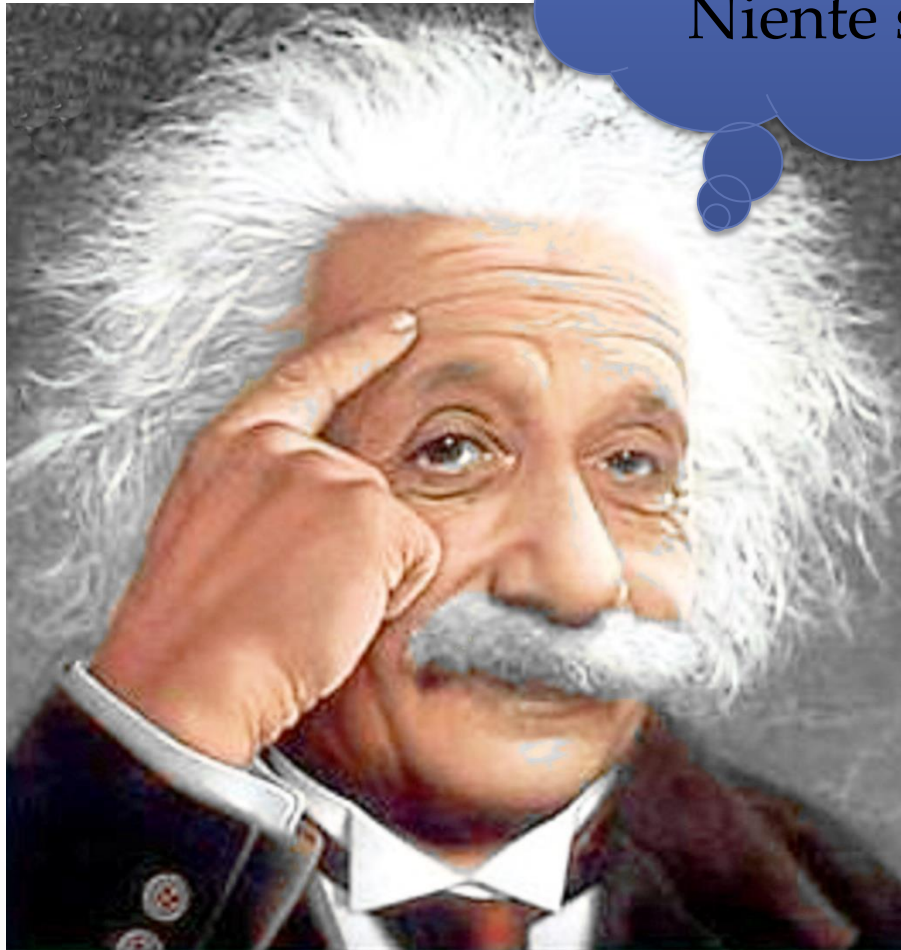| Recommendations	Class[a]	Level[b]	Ref.[c]
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2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS

The Task Force for dual antiplatelet therapy in coronary artery disease of the European Society of Cardiology (ESC) and of the European Association for Cardio-Thoracic Surgery (EACTS)

Authors/Task Force Members: Marco Valgimigli* (Chairperson) (Switzerland), Héctor Bueno (Spain), Robert A. Byrne (Germany), Jean-Philippe Collet (France), Francesco Costa (Italy), Anders Jeppsson[1] (Sweden), Peter Jüni (Canada), Adnan Kastrati (Germany), Philippe Kolh (Belgium), Laura Mauri (USA), Gilles Montalescot (France), Franz-Josef Neumann (Germany), Mate Petricevic[1] (Croatia), Marco Roffi (Switzerland), Philippe Gabriel Steg (France), Stephan Windecker (Switzerland), and Jose Luis Zamorano (Spain)
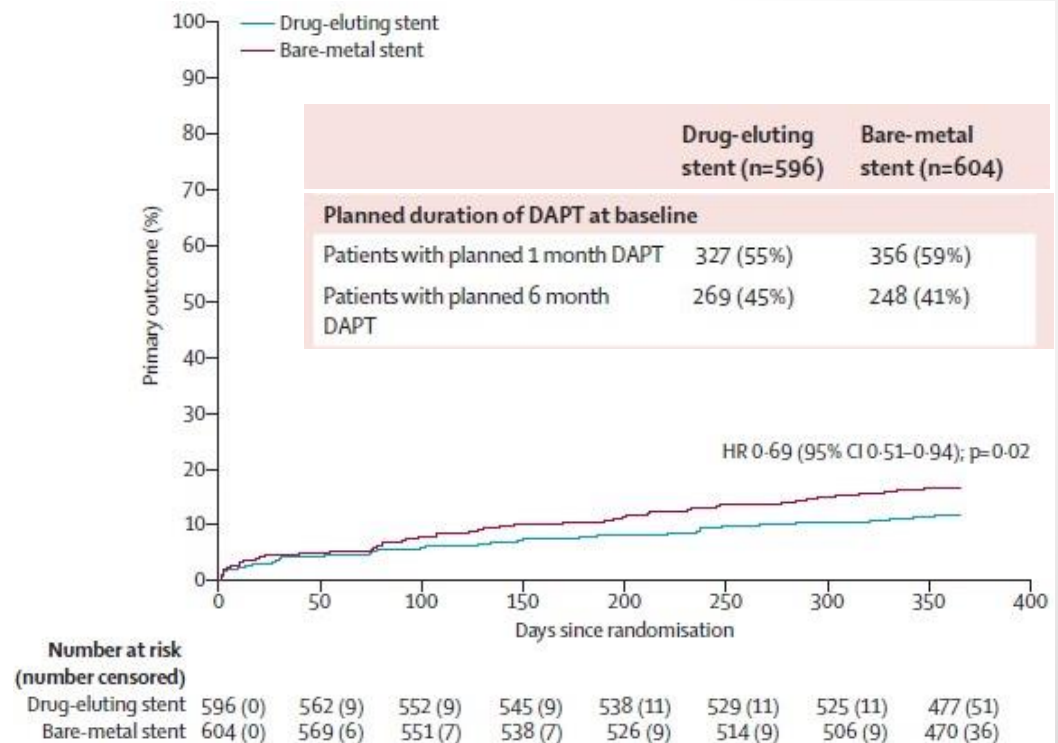
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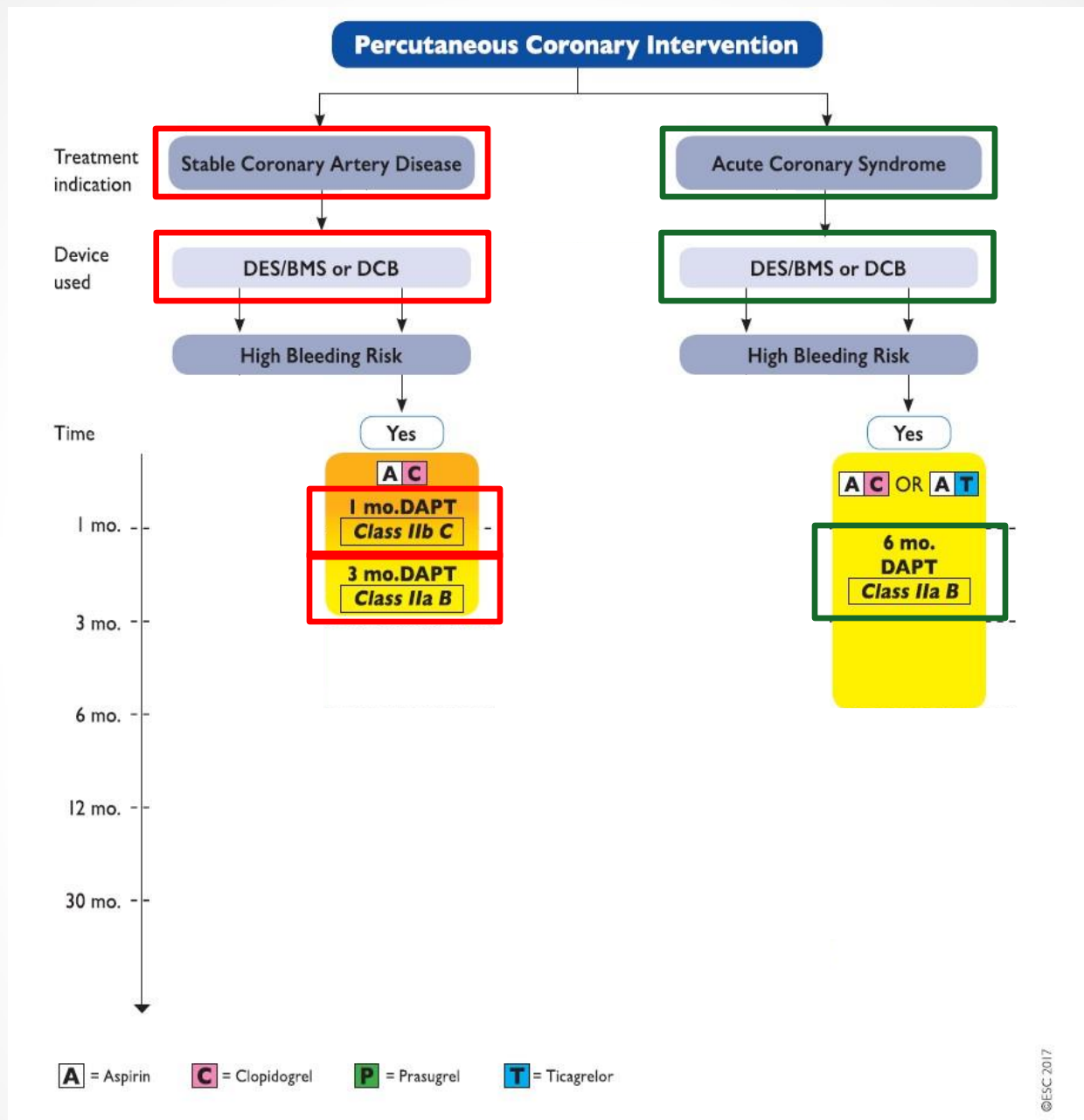
Drug-eluting stents in elderly patients with coronary artery disease (SENIOR): a randomised single-blind trial
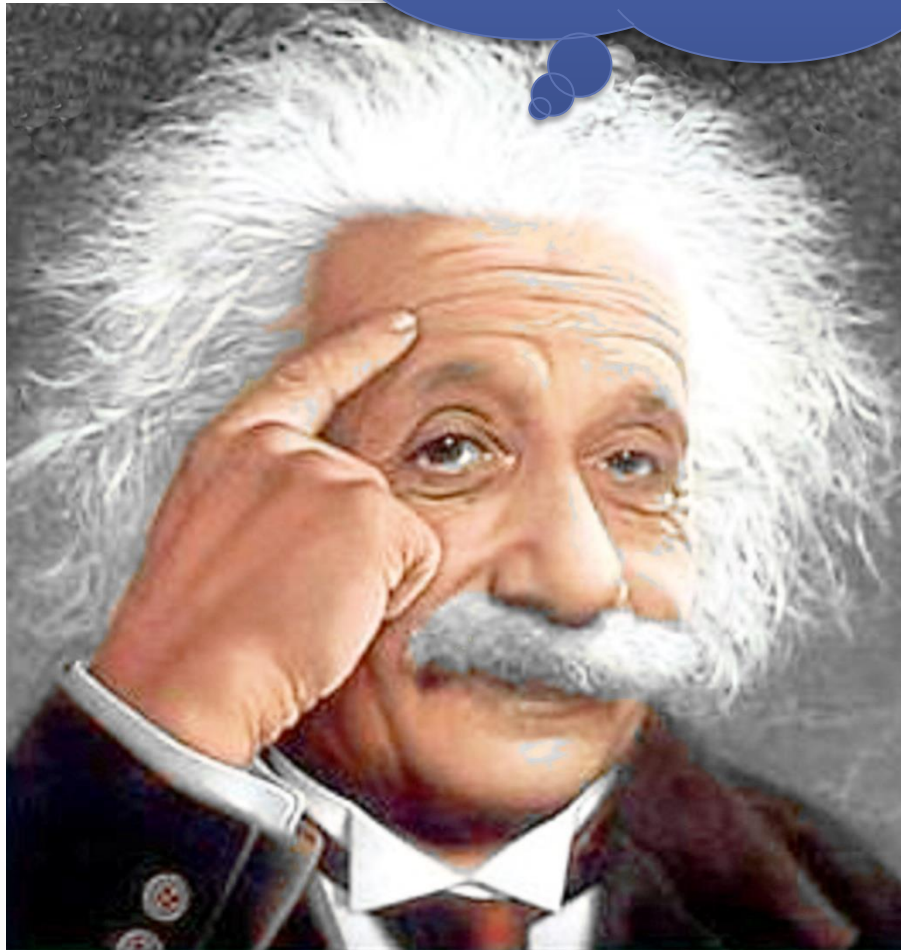
Olivier Varenne, Stéphane Cook, Georgios Sideris, Sasko Kedev, Thomas Cuisset, Didier Carrié, Thomas Hovasse, Philippe Garot, Rami El Mahmoud, Christian Spaulding, Gérard Helft, José F Diaz Fernandez, Salvatore Brugaletta, Eduardo Pinar-Bermudez, Josepa Mauri Ferre, Philippe Commeau, Emmanuel Teiger, Kris Bogaerts, Manel Sabate, Marie-Claude Morice, Peter R Sinnaeve, for the SENIOR investigators

	Drug-eluting stent (n=596)	Bare-metal stent (n=604)
Baseline characteristics		
Age (years)	81·4 (4·3)	81·4 (4·2)
Male sex	368 (62%)	379 (63%)
BMI (kg/m²)	26·3 (4·3)	25·9 (3·9)
Medical history		
Diabetes	158/594 (27%)	157/603 (26%)
Current smoker	43/596 (7%)	38/604 (6%)
Renal insufficiency at screening	104/593 (18%)	99/604 (16%)
Hypercholesterolaemia	311/596 (52%)	320/604 (53%)
Hypertension	427/596 (72%)	488/604 (81%)
Previous stroke	39/593 (7%)	48/604 (8%)
History of malignancy (past 3 years)	56/593 (9%)	51/601 (8%)
Congestive heart failure	36/596 (6%)	40/603 (7%)
Previous MI	109/595 (18%)	80/602 (13%)
Previous CABG	36/596 (6%)	42/604 (7%)
Previous PCI	139/595 (23%)	143/604 (24%)
Peripheral vascular disease	87/592 (15%)	125/596 (21%)
Atrial fibrillation	103/594 (17%)	108/602 (18%)
Anaemia	77/556 (14%)	84/560 (15%)

	Drug-eluting stent (n=596)	Bare-metal stent (n=604)
Planned duration of DAPT at baseline		
Patients with planned 1 month DAPT	327 (55%)	356 (59%)
Patients with planned 6 month DAPT	269 (45%)	248 (41%)

HR 0·69 (95% CI 0·51–0·94); p=0·02

Number at risk (number censored)

Drug-eluting stent	596 (0)	562 (9)	552 (9)	545 (9)	538 (11)	529 (11)	525 (11)	477 (51)
Bare-metal stent	604 (0)	569 (6)	551 (7)	538 (7)	526 (9)	514 (9)	506 (9)	470 (36)

CONCLUSIONI

1. Il paziente "fragile" con Sindrome Coronarica Acuta è un paziente che dobbiamo avviare a trattamento invasivo (farmacologico e interventistico) ottimizzato (_angioplastica coronarica_)

2. Ottimizzare significa utilizzare farmaci adeguati a dosaggi adeguati (_valutare doppia dose di carico della DAPT nei pazienti over 75 con NSTEMI_) e per un tempo adeguato (_3 o 6 mesi_)

3. Ottimizzare significa utilizzare anche materiali sicuri ed efficaci (_stent medicati_)

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Grazie per l'attenzione