

2022

SCASEST

¿Estrategia invasiva a todos?

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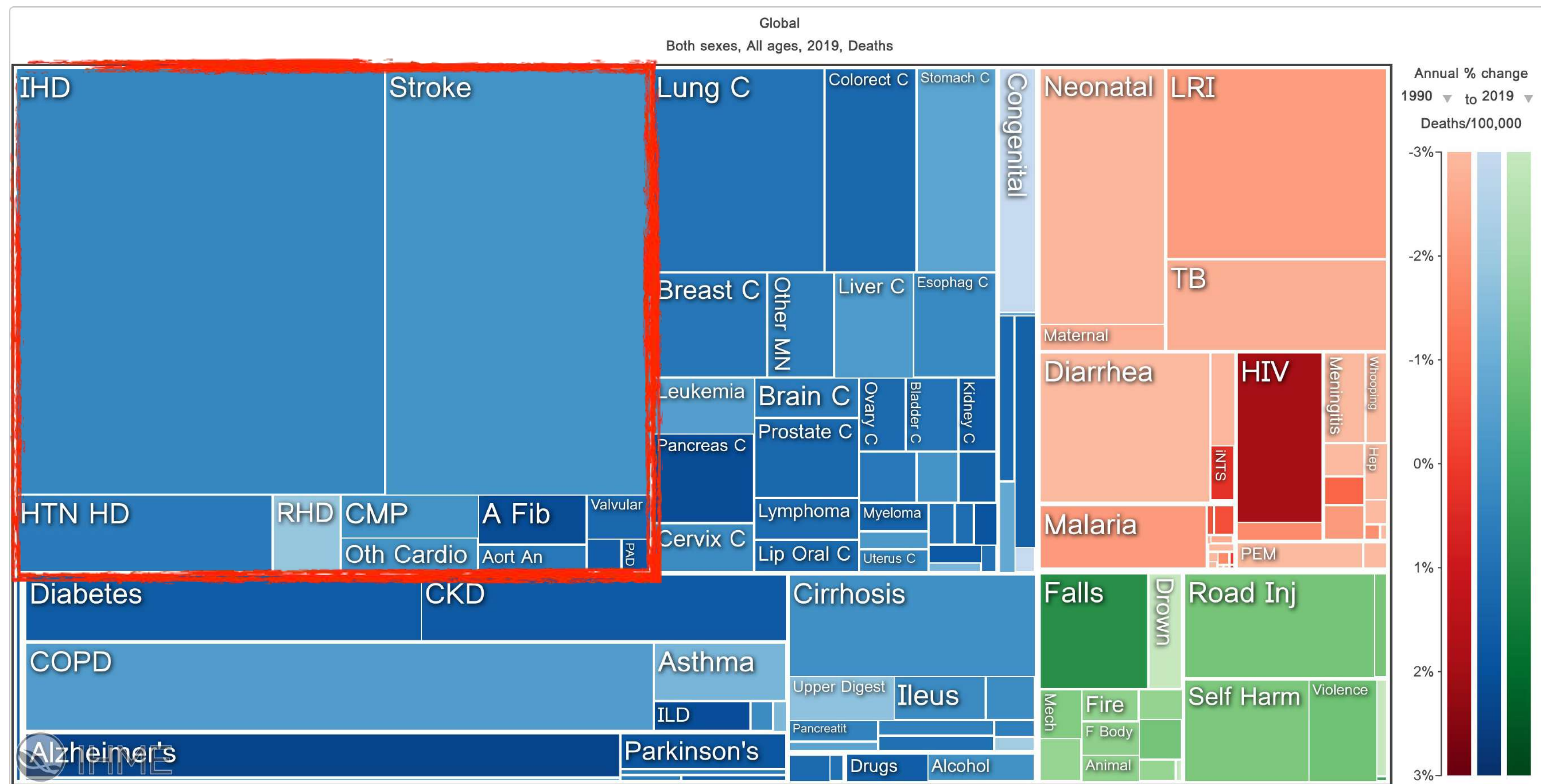
XLIV Jornadas SOLACI

DECLARACIÓN DE CONFLICTOS DE INTERÉS

- Sin conflictos de interés.

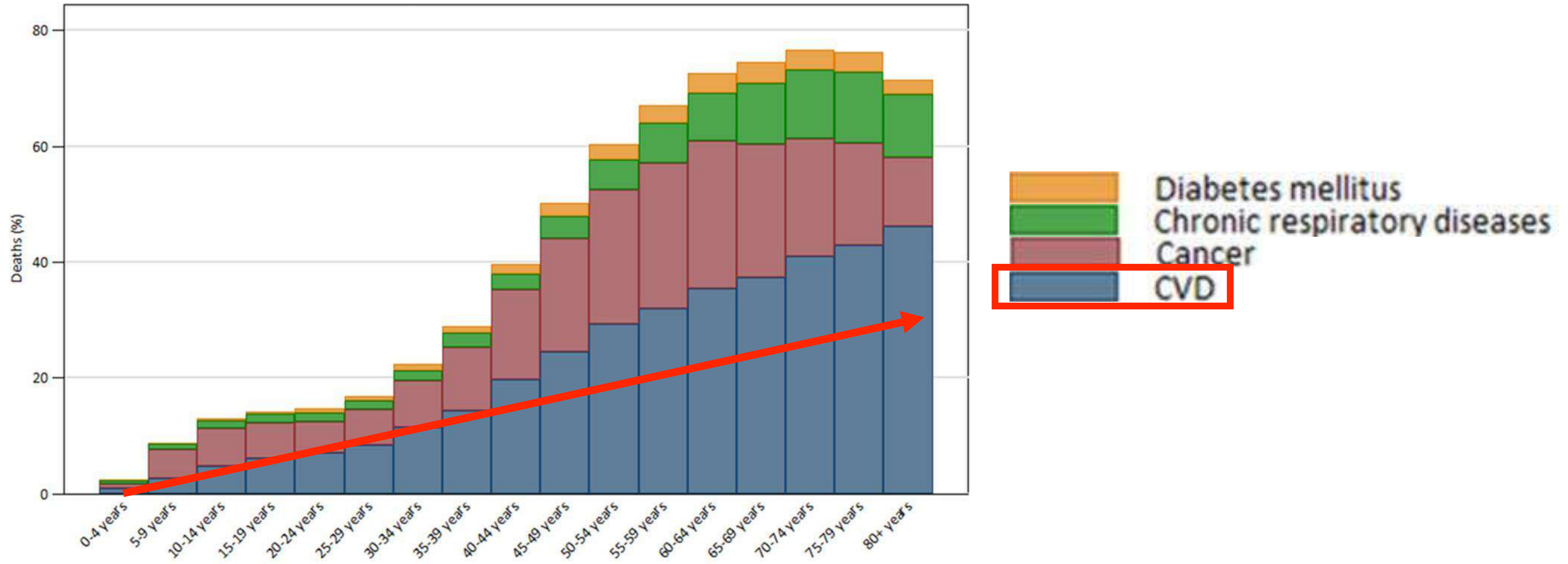


¿POR QUÉ HABLAR DE ESTE TEMA Y CUÁL LA RELEVANCIA DE ENFOCARNOS EN UN MANEJO ACTUALIZADO?



Fuente: 1. IHME Institute for Health Metrics and Evaluation Population Health Building/Hans Rosling Center <https://vizhub.healthdata.org/gbd-compare/>

¿POR QUÉ HABLAR DE ESTE TEMA Y CUÁL LA RELEVANCIA DE ENFOCARNOS EN UN MANEJO ACTUALIZADO?



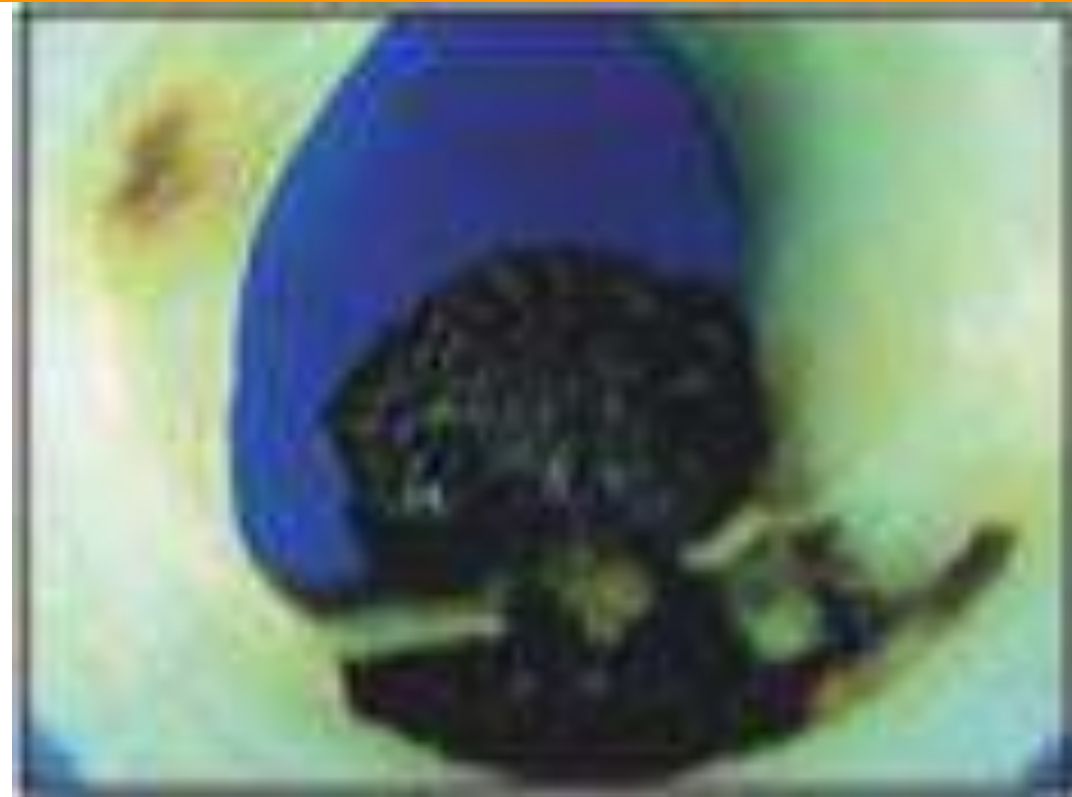
Fuente: 1. Gaziano TA, Gaziano JM. Epidemiología de las enfermedades cardiovasculares. En: Jameson JL, Fauci AS, et al. Harrison principios de medicina interna. 20va Ed. México: McGraw-Hill. 2018. 1662-1666.
 2. Gregory A, Roth et al. Circulation. 2015;132:1667-1678.

SÍNDROME CORONARIO AGUDO SIN ELEVACIÓN DEL SEGMENTO ST

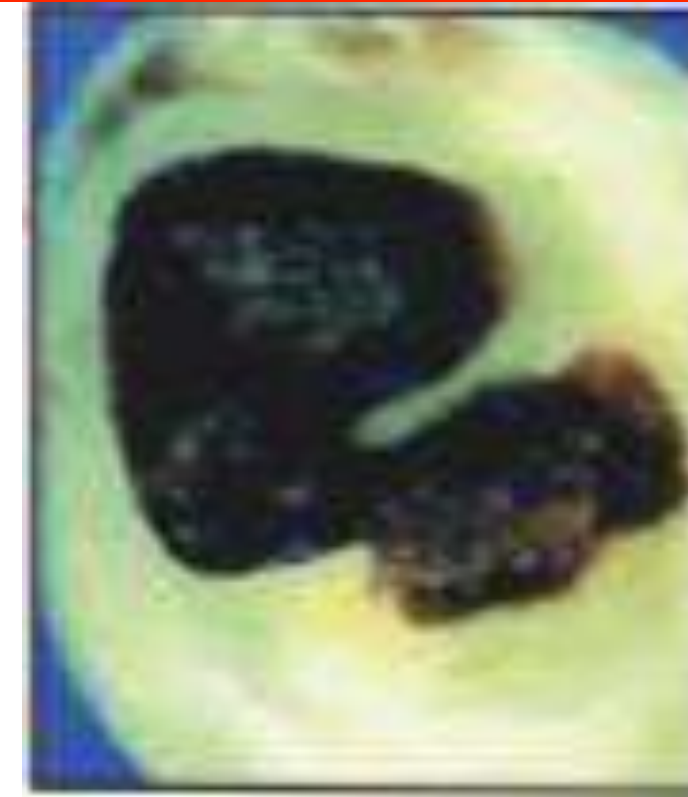
SÍNDROME CORONARIO AGUDO

ELECTROCARDIOGRAMA

SIN SUPRADESNIVEL ST



SUPRADESNIVEL ST



Fuente:

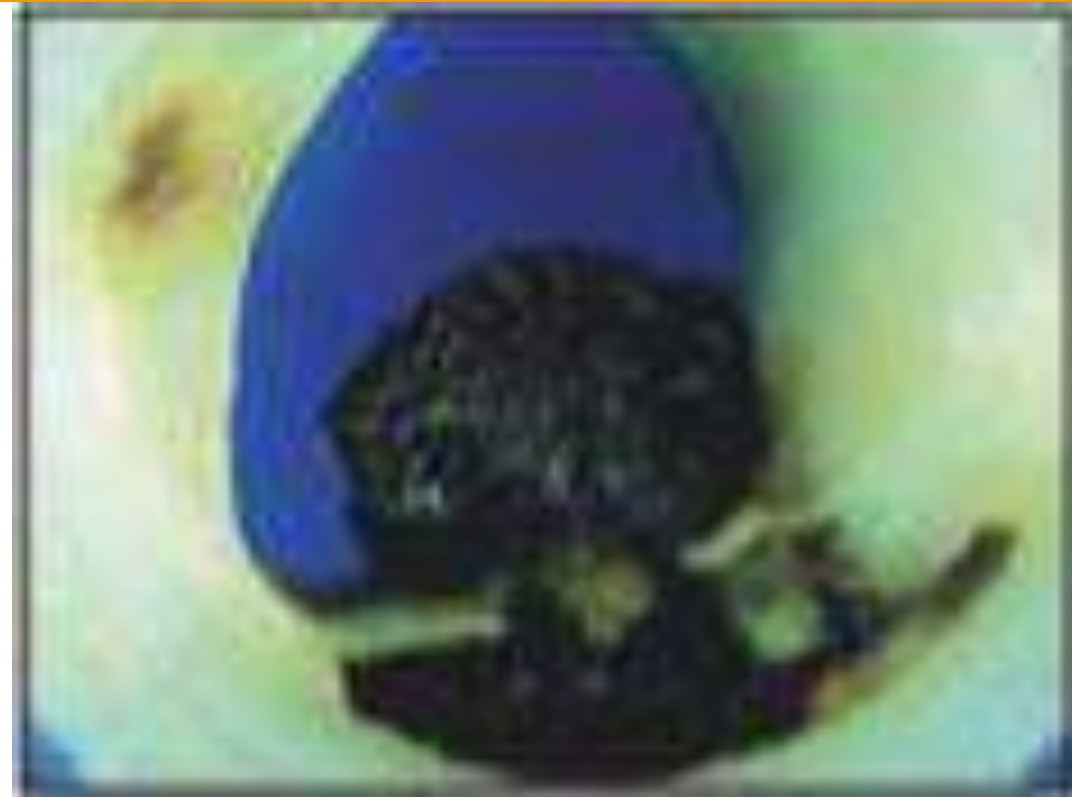
1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Adapted from CW Hamm et al: Lancet 358:1533, 2001, and MJ Davies: Heart 83:361, 2000.
3. PLoS One. 2020 Jan 10;15(1):e0226892. doi: 10.1371/journal.pone.0226892. eCollection 2020.

SÍNDROME CORONARIO AGUDO SIN ELEVACIÓN DEL SEGMENTO ST

SÍNDROME CORONARIO AGUDO

ELECTROCARDIOGRAMA

SIN SUPRADESNIVEL ST



TROPONINA

NEGATIVA

POSITIVA

ANGINA INESTABLE

INFARTO DE MIOCARDIO

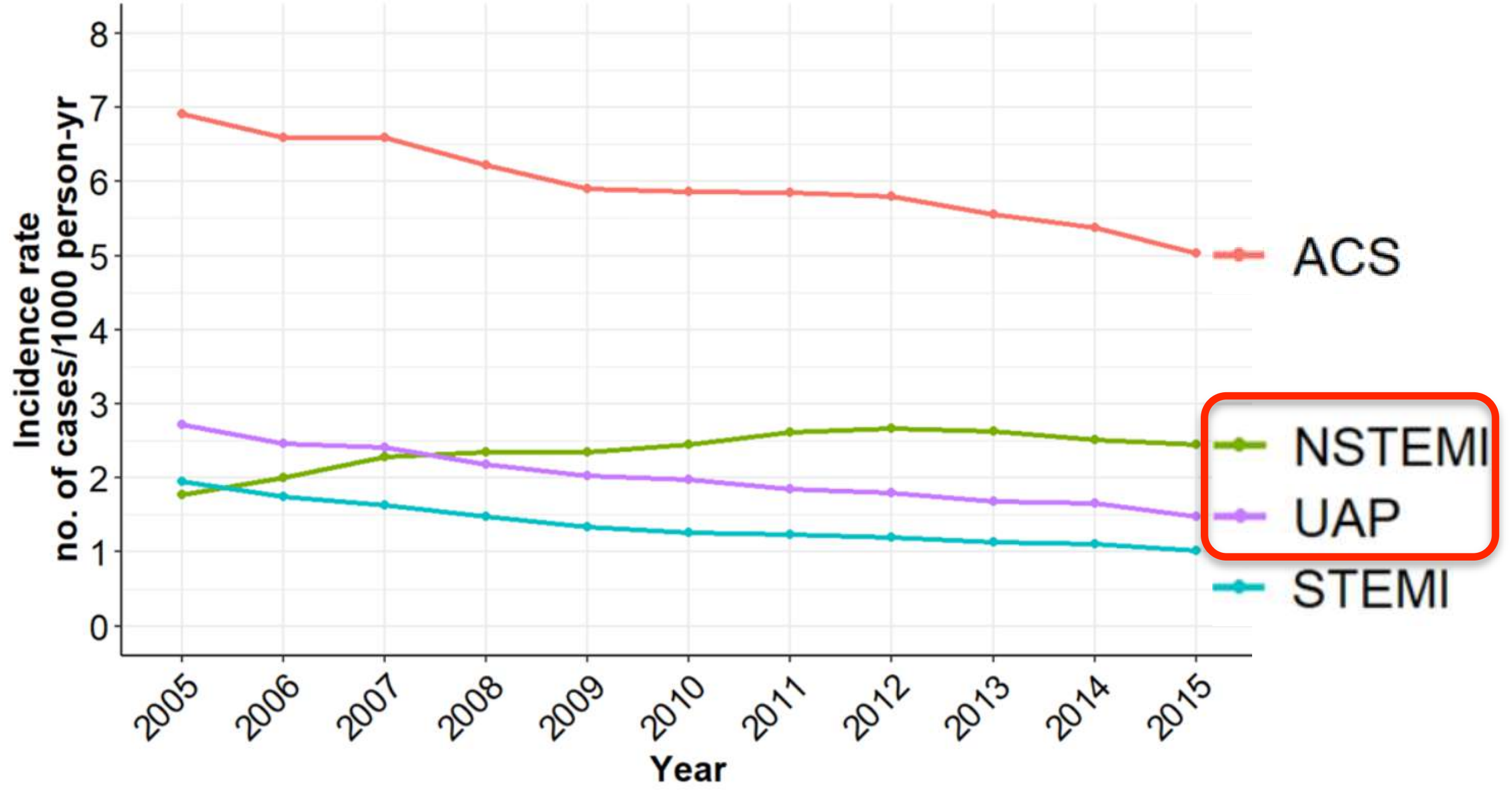
Fuente:

1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Adapted from CW Hamm et al: Lancet 358:1533, 2001, and MJ Davies: Heart 83:361, 2000.
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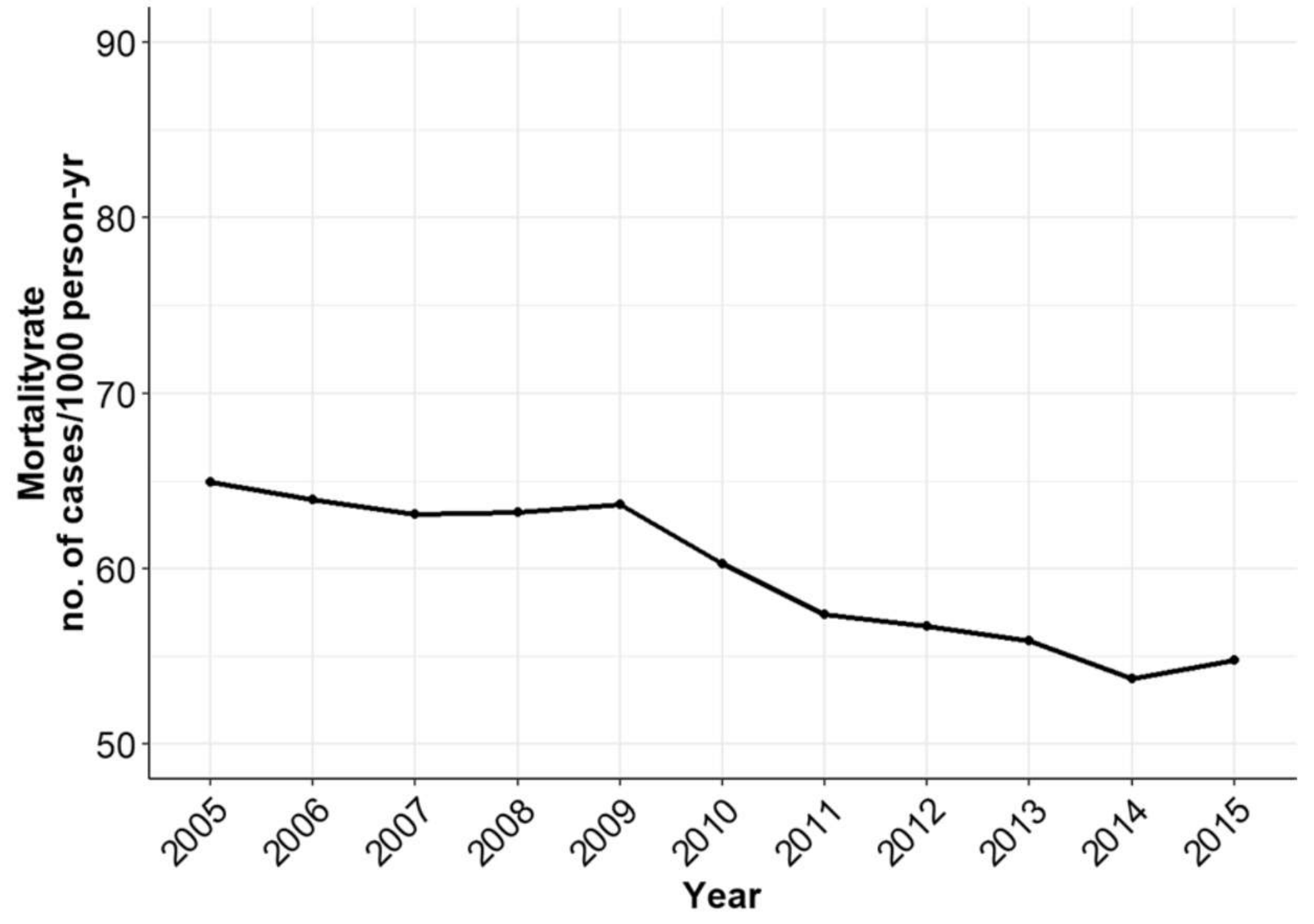
¿POR QUÉ HABLAR DE ESTE TEMA Y CUÁL LA RELEVANCIA DE ENFOCARNOS EN UN MANEJO ACTUALIZADO?

Temporal trends in incidence and outcome of acute coronary syndrome

Incidence rate



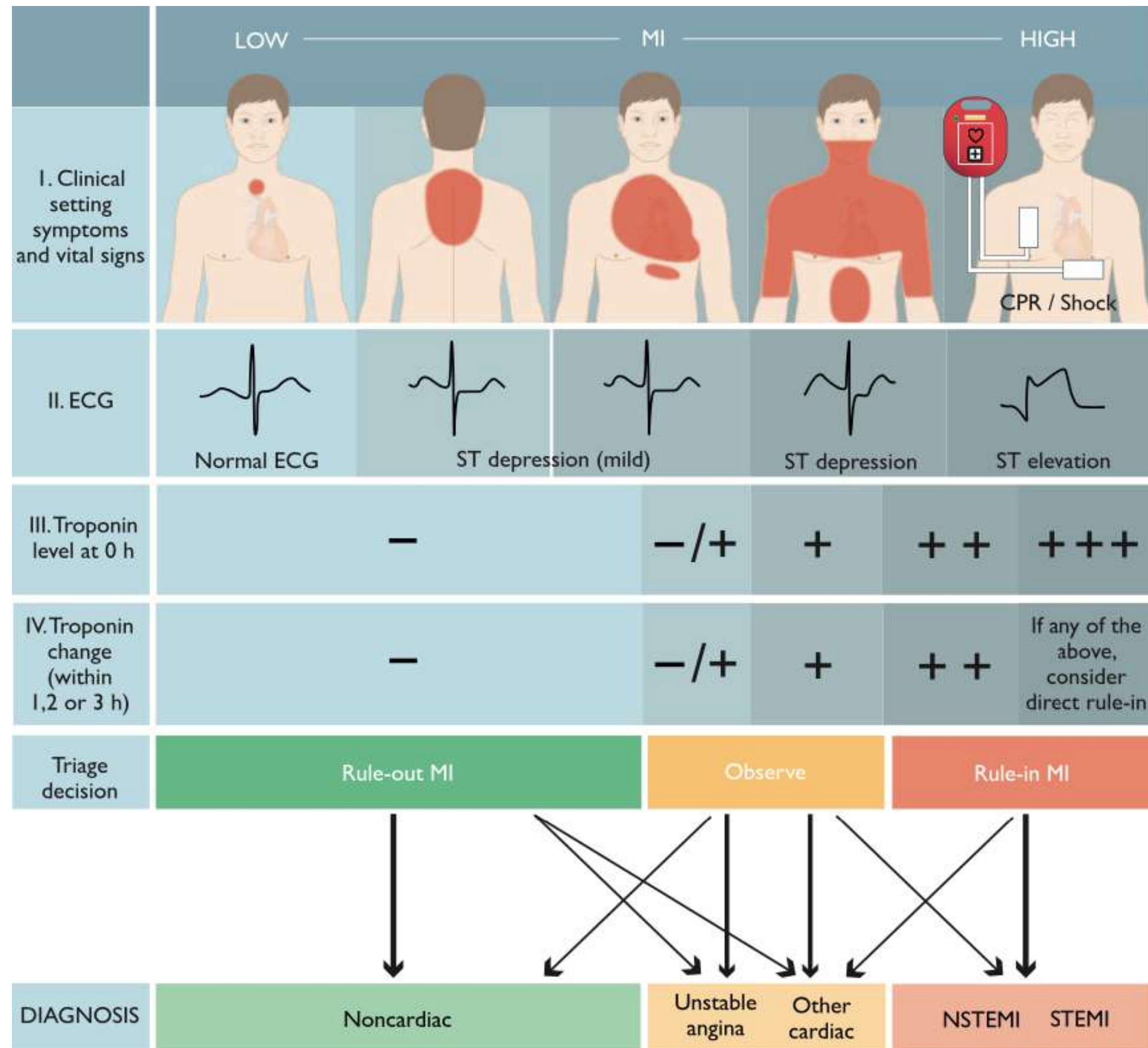
Mortality rate



Fuente:

1. Clin Res Cardiol. 2020 Sep;109(9):1186-1192. doi: 10.1007/s00392-020-01612-1. Epub 2020 Feb 7.
2. Curr Cardiol Rep. 2019 Apr 10;21(5):39. doi: 10.1007/s11886-019-1125-9.
3. Heart. 2019 Sep;105(18):1423-1431. doi: 10.1136/heartjnl-2018-314305. Epub 2019 Apr 24.

SÍNDROME CORONARIO AGUDO SIN ELEVACIÓN DEL SEGMENTO ST



• 50% Enfermedades NO cardiológicas.

• 15% - 20% IAMSEST.

• 15% Otras patologías cardiacas.

• 10% Angina inestable.

• 5% - 10% IAMCEST.

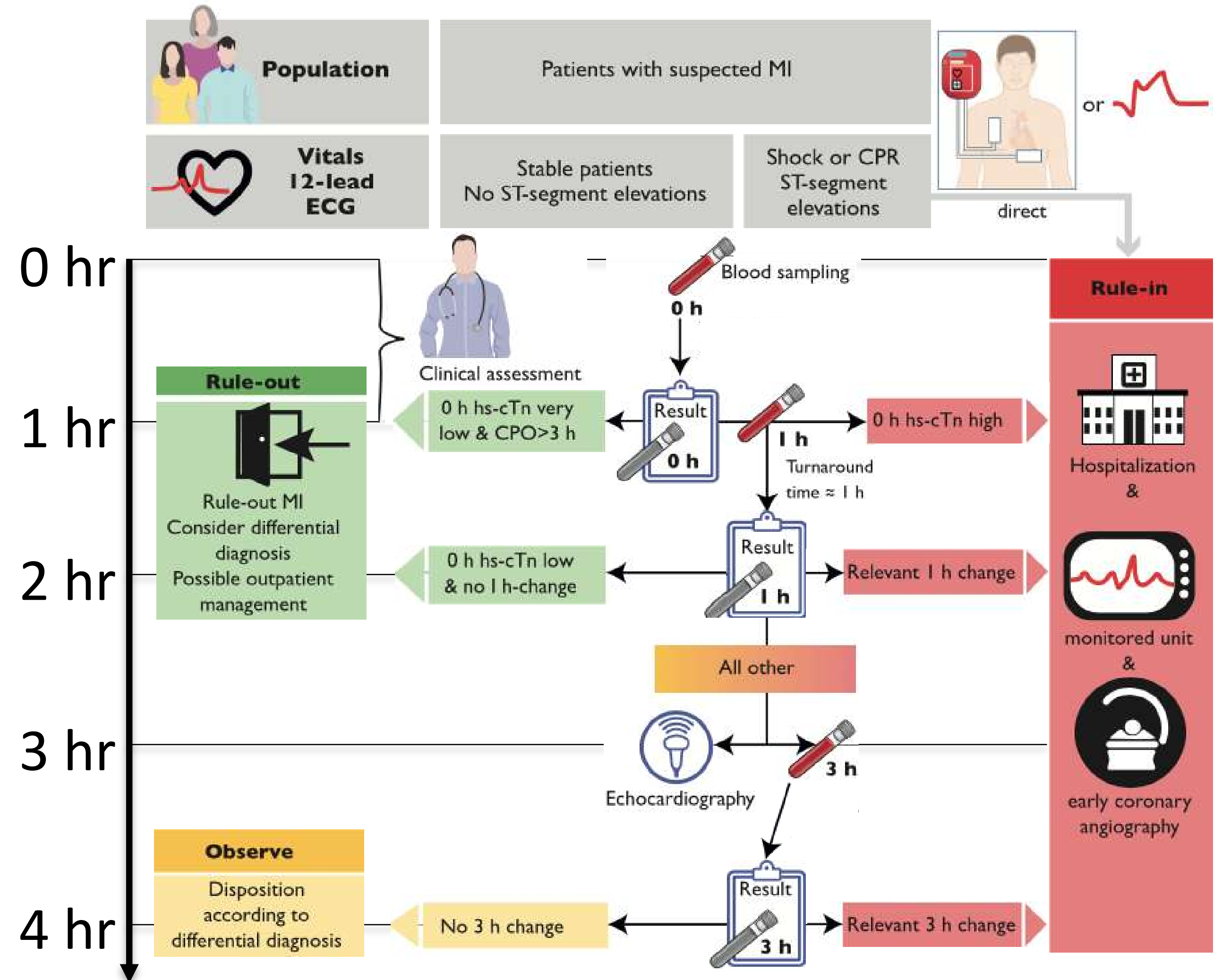
25% - 30%

Fuente:

1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Eur Heart J Acute Cardiovasc Care. 2020 Feb;9(1):76-89. doi: 10.1177/2048872619885346. Epub 2020 Jan 20.

ABORDAJE DEL PACIENTE EN LA EMERGENCIA

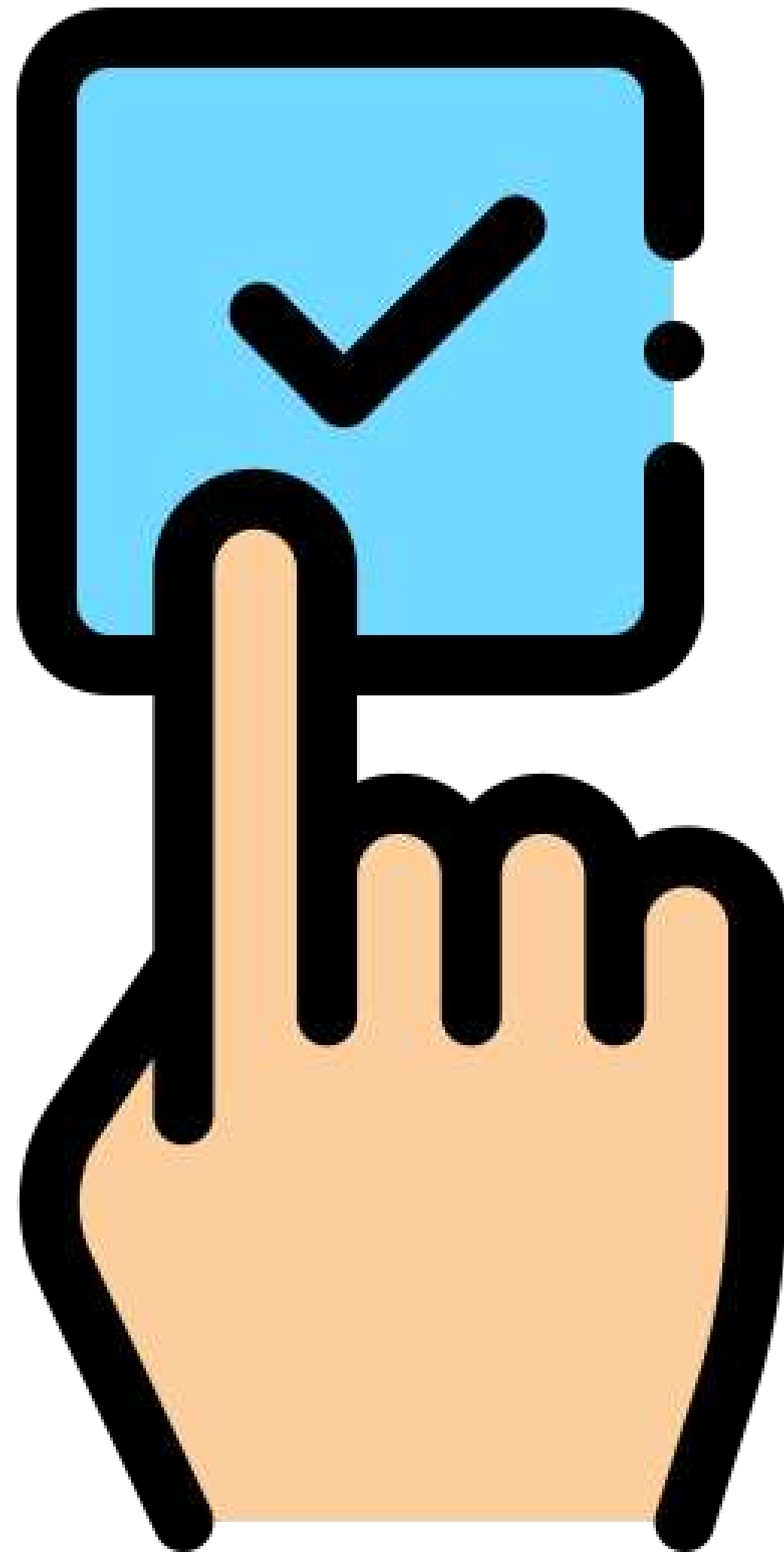
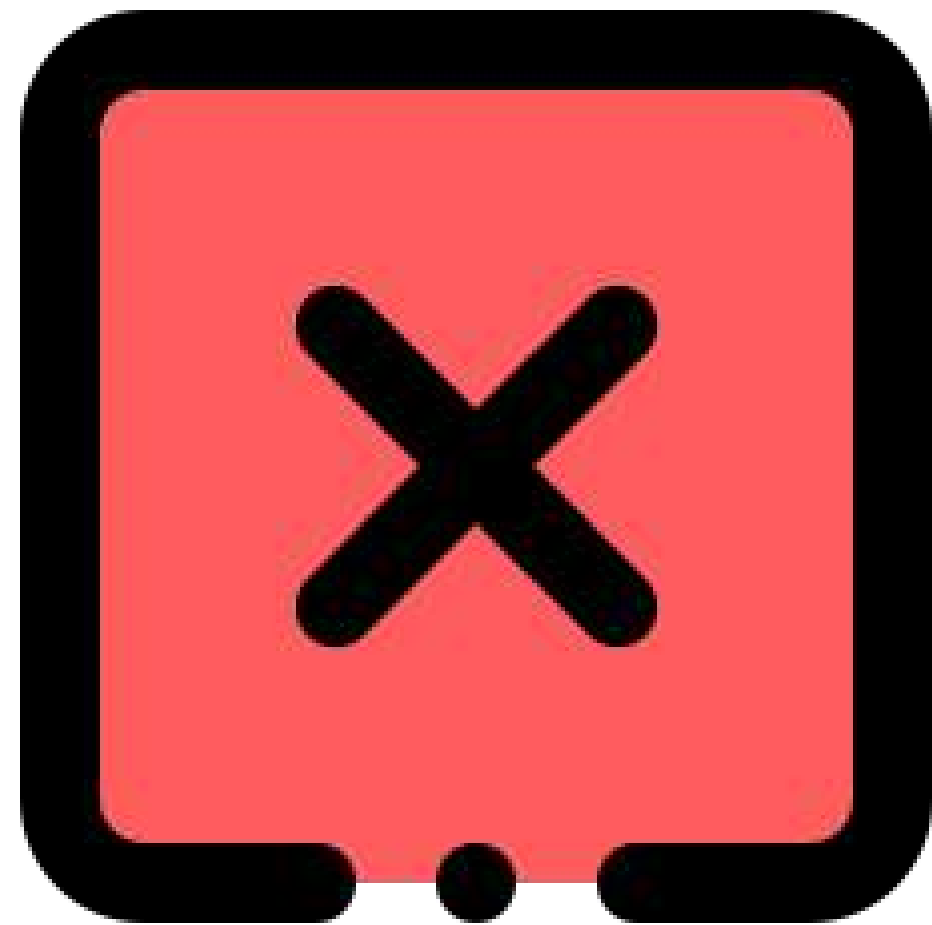
Risk of	Low risk	Intermediate risk	High risk
MI at index visit	<0.3%	≈ 10%	>65%
30-day MACE	<0.5%	15–20%	>70%



Fuente:

1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Eur Heart J Acute Cardiovasc Care. 2020 Feb;9(1):76-89. doi: 10.1177/2048872619885346. Epub 2020 Jan 20.

¿ESTRATEGIA INVASIVA PARA TODOS?

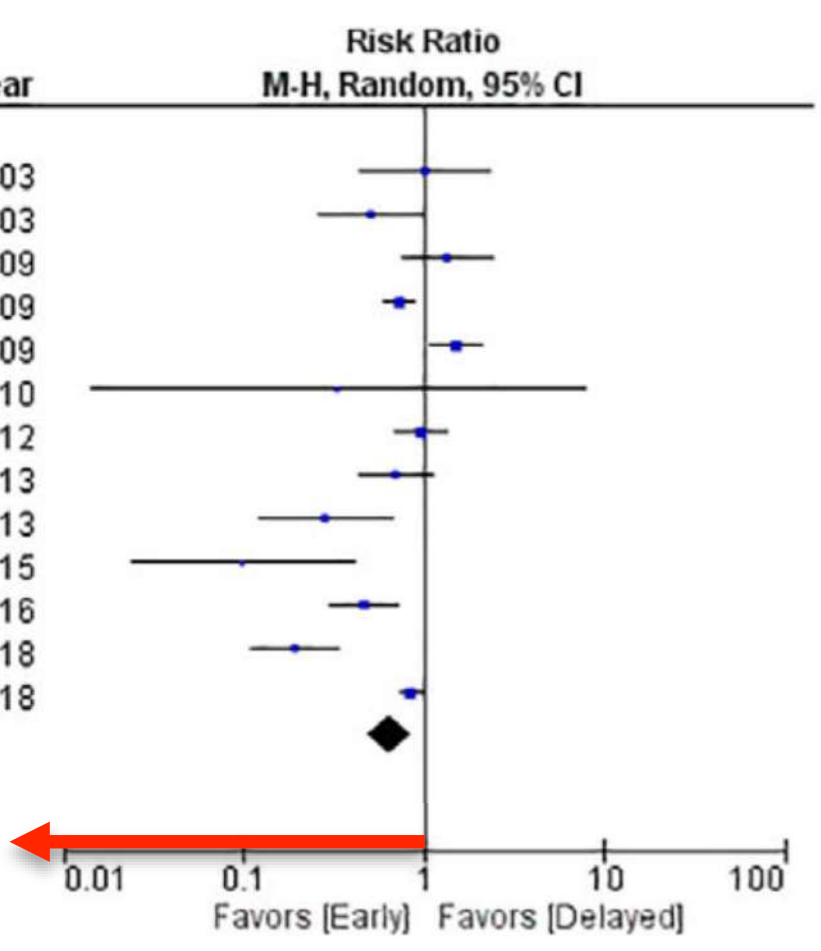


¿POR QUÉ ES IMPORTANTE IDENTIFICAR LA CORRECTA ESTRATEGIA INVASIVA EN ESTOS PACIENTES?

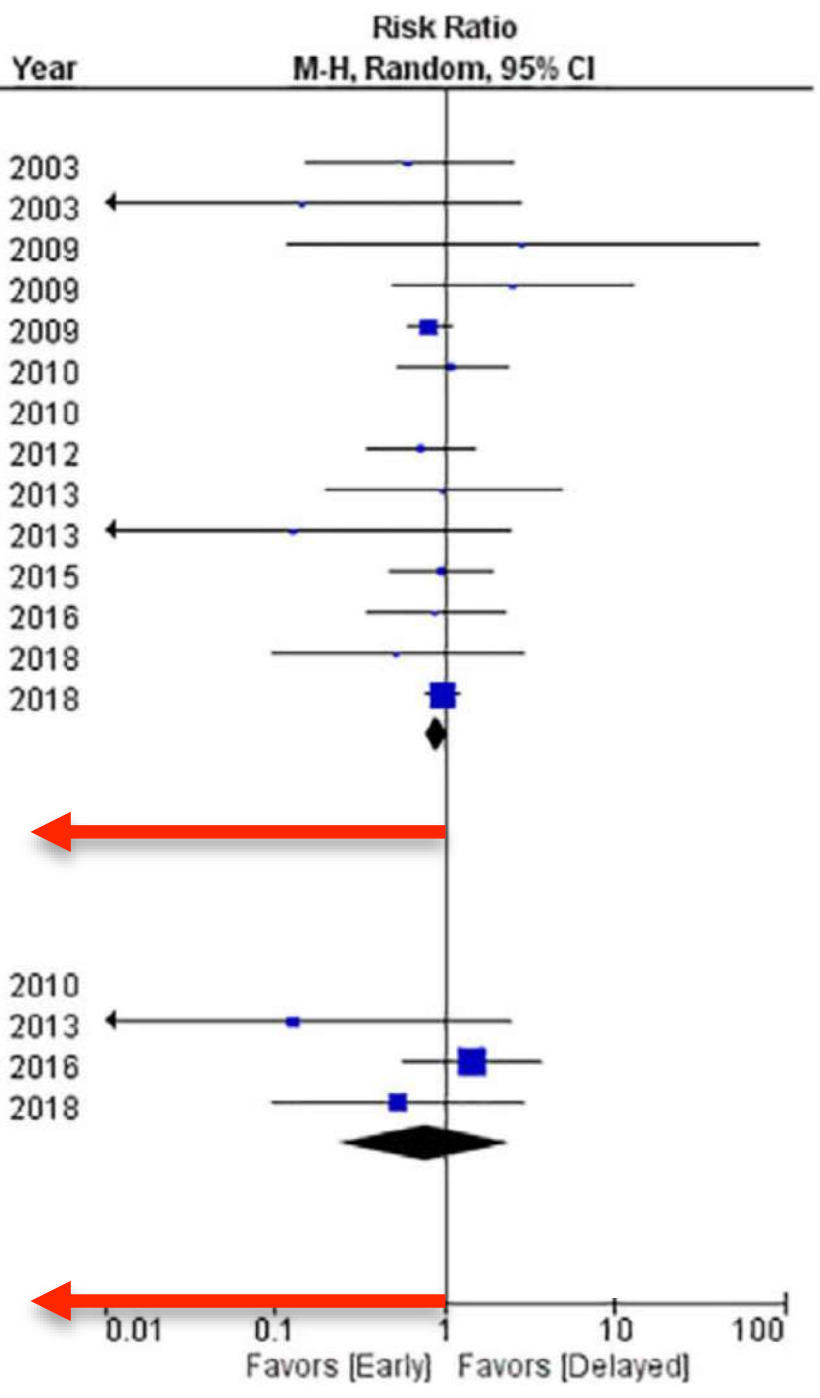
Meta-analysis of optimal timing of coronary intervention in non-ST-elevation acute coronary syndrome

Forest plot of the efficacy outcomes

Study or Subgroup	Early intervention Events	Early intervention Total	Delayed intervention Events	Delayed intervention Total	Weight	Risk Ratio M-H, Random, 95% CI	Year
1.1.1 MACE							
ELISA 2003	10	109	10	111	5.8%	1.02 [0.44, 2.35]	2003
ISAR-COOL 2003	12	203	24	207	7.2%	0.51 [0.26, 0.99]	2003
ABOARD 2009	24	175	18	177	8.0%	1.35 [0.76, 2.39]	2009
TIMACS 2009	151	1593	186	1438	11.1%	0.73 [0.60, 0.90]	2009
OPTIMA 2009	48	73	30	69	10.3%	1.51 [1.10, 2.07]	2009
Sciahbasi et al 2010	0	27	1	27	0.8%	0.33 [0.01, 7.84]	2010
LIPSIA-NSTEMI 2012	42	200	87	400	10.2%	0.97 [0.70, 1.34]	2012
ELISA-3 2013	27	269	38	265	9.0%	0.70 [0.44, 1.11]	2013
Tekin et al 2013	6	69	19	62	5.7%	0.28 [0.12, 0.66]	2013
SISCA 2015	2	83	21	86	3.0%	0.10 [0.02, 0.41]	2015
RIDDLE-NSTEMI 2016	25	162	53	161	9.4%	0.47 [0.31, 0.72]	2016
EARLY 2018	14	346	75	363	8.2%	0.20 [0.11, 0.34]	2018
VERDICT 2018	269	1075	316	1072	11.5%	0.85 [0.74, 0.98]	2018
Subtotal (95% CI)		4384		4438	100.0%	0.65 [0.49, 0.87]	
Total events	630		878				
Heterogeneity: Tau ² = 0.18; Chi ² = 71.74, df = 12 (P < 0.00001); I ² = 83%							
Test for overall effect: Z = 2.93 (P = 0.003)							



Study or Subgroup	Early intervention Events	Early intervention Total	Delayed intervention Events	Delayed intervention Total	Weight	Risk Ratio M-H, Random, 95% CI	Year
1.1.2 All-cause mortality							
ELISA 2003	3	109	5	111	1.3%	0.61 [0.15, 2.49]	2003
ISAR-COOL 2003	0	203	3	207	0.3%	0.15 [0.01, 2.80]	2003
OPTIMA 2009	1	73	0	69	0.2%	2.84 [0.12, 68.51]	2009
ABOARD 2009	5	175	2	177	1.0%	2.53 [0.50, 12.86]	2009
TIMACS 2009	76	1593	85	1438	27.8%	0.81 [0.60, 1.09]	2009
Zhang et al 2010	16	446	12	369	4.7%	1.10 [0.53, 2.30]	2010
Sciahbasi et al 2010	0	27	0	27		Not estimable	2010
LIPSIA-NSTEMI 2012	9	200	25	400	4.6%	0.72 [0.34, 1.51]	2012
ELISA-3 2013	3	269	3	265	1.0%	0.99 [0.20, 4.84]	2013
Tekin et al 2013	0	69	3	62	0.3%	0.13 [0.01, 2.44]	2013
SISCA 2015	13	83	14	86	5.3%	0.96 [0.48, 1.92]	2015
RIDDLE-NSTEMI 2016	8	162	9	161	2.9%	0.88 [0.35, 2.23]	2016
EARLY 2018	2	346	4	363	0.9%	0.52 [0.10, 2.85]	2018
VERDICT 2018	131	1075	135	1072	49.8%	0.97 [0.77, 1.21]	2018
Subtotal (95% CI)		4830		4807	100.0%	0.90 [0.77, 1.06]	
Total events	267		300				
Heterogeneity: Tau ² = 0.00; Chi ² = 7.48, df = 12 (P = 0.82); I ² = 0%							
Test for overall effect: Z = 1.29 (P = 0.20)							
1.1.3 Cardiovascular mortality							
Sciahbasi et al 2010	0	27	0	27		Not estimable	2010
Tekin et al 2013	0	69	3	62	13.2%	0.13 [0.01, 2.44]	2013
RIDDLE-NSTEMI 2016	8	162	9	261	56.1%	1.43 [0.56, 3.64]	2016
EARLY 2018	2	346	4	363	30.7%	0.52 [0.10, 2.85]	2018
Subtotal (95% CI)		604		713	100.0%	0.77 [0.24, 2.44]	
Total events	10		16				
Heterogeneity: Tau ² = 0.40; Chi ² = 3.09, df = 2 (P = 0.21); I ² = 35%							
Test for overall effect: Z = 0.45 (P = 0.65)							

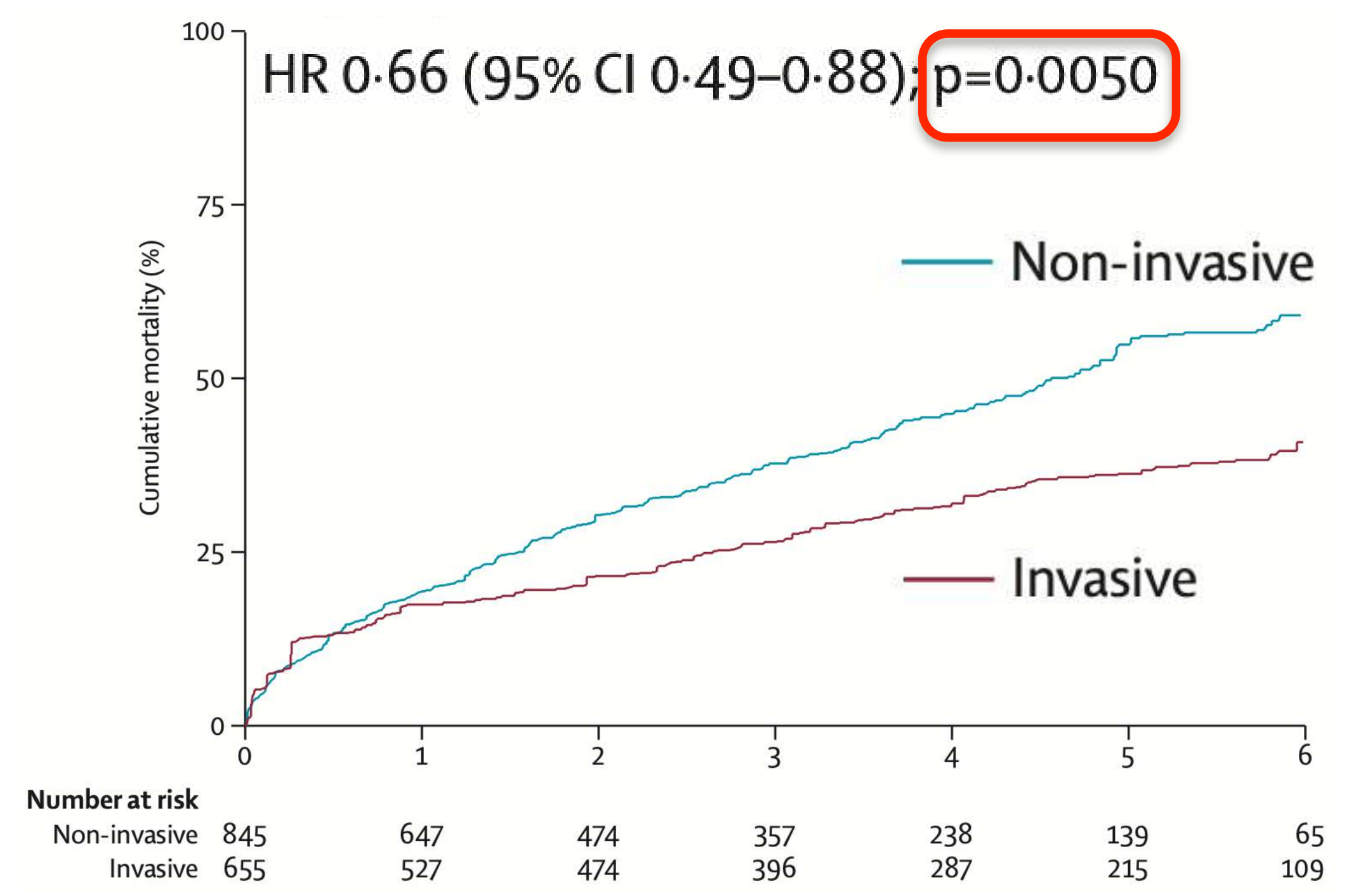


Fuente: 1. Catheter Cardiovasc Interv. 2020 Feb;95(2):185-193. doi: 10.1002/ccd.28280. Epub 2019 May 21.
2. J Interv Cardiol. 2020 Mar 3;2020:8513257. doi: 10.1155/2020/8513257. eCollection 2020.

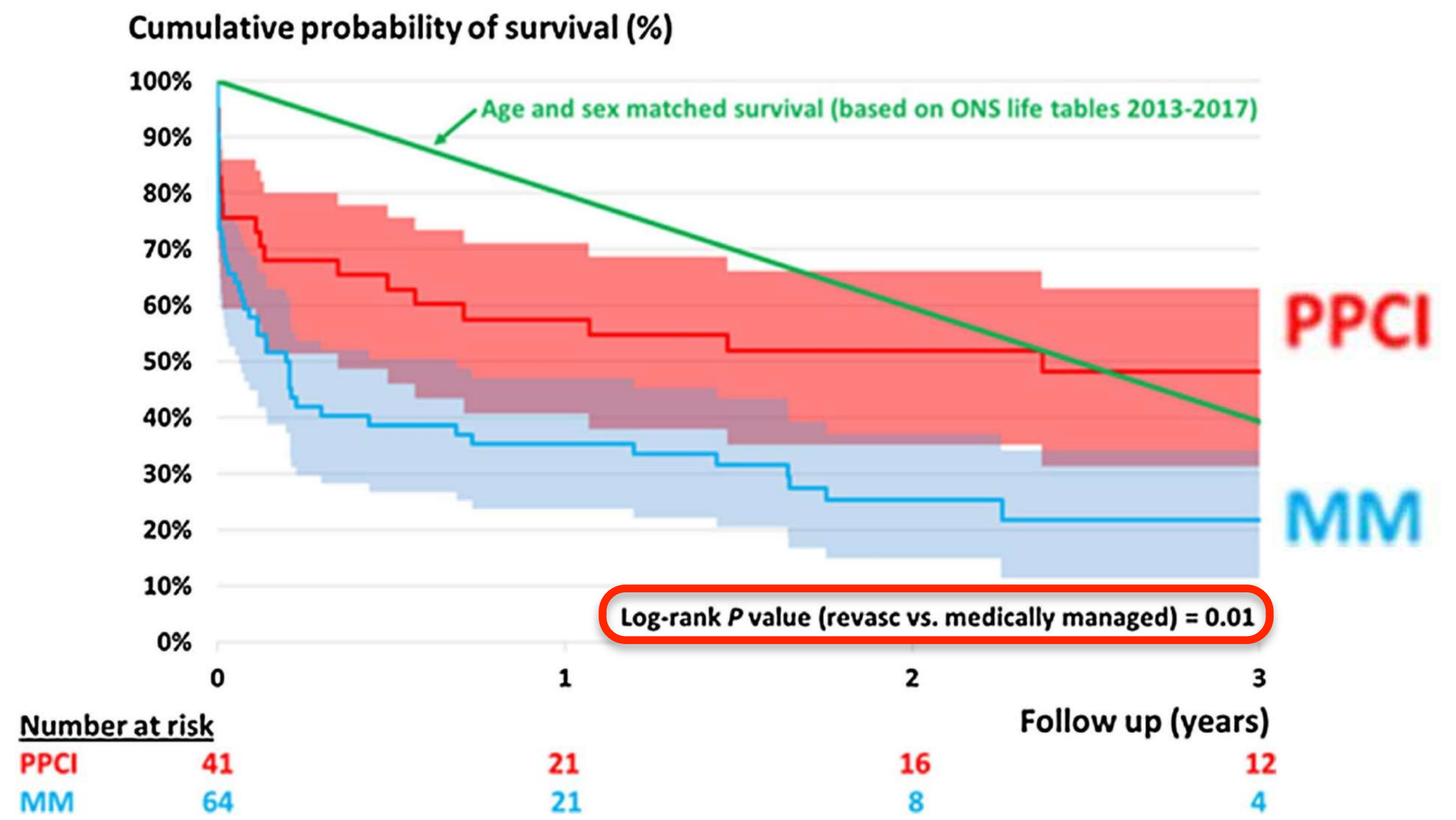
¿POR QUÉ ES IMPORTANTE IDENTIFICAR LA CORRECTA ESTRATEGIA INVASIVA EN ESTOS PACIENTES?

Invasive versus non-invasive management of older patients with NSTEMI

Kaplan Meier for all-cause of mortality (>80 years)



Kaplan Meier for all-cause of mortality (>90 years)



Fuente:

1. BMC Cardiovasc Disord. 2021 Jan 13;21(1):30. doi: 10.1186/s12872-020-01833-2.
2. Lancet. 2020 Aug 29;396(10251):623-634. doi: 10.1016/S0140-6736(20)30930-2.
3. J Interv Cardiol. 2020 Mar 3;2020:8513257. doi: 10.1155/2020/8513257. eCollection 2020.

¿POR QUÉ ES IMPORTANTE IDENTIFICAR LA CORRECTA ESTRATEGIA INVASIVA EN ESTOS PACIENTES?

- Una estrategia invasiva rutinaria **NO REDUCE** el riesgo de mortalidad por cualquier causa, en la población general de pacientes con SCASEST.
- Una estrategia invasiva rutinaria **INCREMENTA** el riesgo de complicaciones relacionadas con el procedimiento, como por ejemplo IAM tipo 4 y sangrado.
- La estrategia invasiva **REDUCE** el riesgo compuesto de eventos isquémicos, en especial en paciente de alto riesgo.

Fuente:

1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Eur Heart J Acute Cardiovasc Care. 2020 Feb;9(1):76-89. doi: 10.1177/2048872619885346. Epub 2020 Jan 20.
3. Heart Vessels. 2016 Jun;31(6):897-906. doi: 10.1007/s00380-015-0695-8. Epub 2015 Jun 6.

¿A QUIENES DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Recommendations for Coronary Angiography and Revascularization in Patients With NSTEMI-ACS

Referenced studies that support the recommendations are summarized in [Online Data Supplement 9](#).

COR	LOE	RECOMMENDATIONS
1	A	1. In patients with NSTEMI-ACS who are at elevated risk of recurrent ischemic events and are appropriate candidates for revascularization, an invasive strategy with the intent to proceed with revascularization is indicated to reduce cardiovascular events (1-4).
1	B-R	2. In patients with NSTEMI-ACS and cardiogenic shock who are appropriate candidates for revascularization, emergency revascularization is recommended to reduce risk of death (5-9).
1	C-LD	3. In appropriate patients with NSTEMI-ACS who have refractory angina or hemodynamic or electrical instability, an immediate invasive strategy with intent to perform revascularization is indicated to improve outcomes (10).

Fuente: 1. J Am Coll Cardiol. 2022 Jan 18;79(2):e21-e129. doi: 10.1016/j.jacc.2021.09.006. Epub 2021 Dec 9.

¿A QUIENES DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

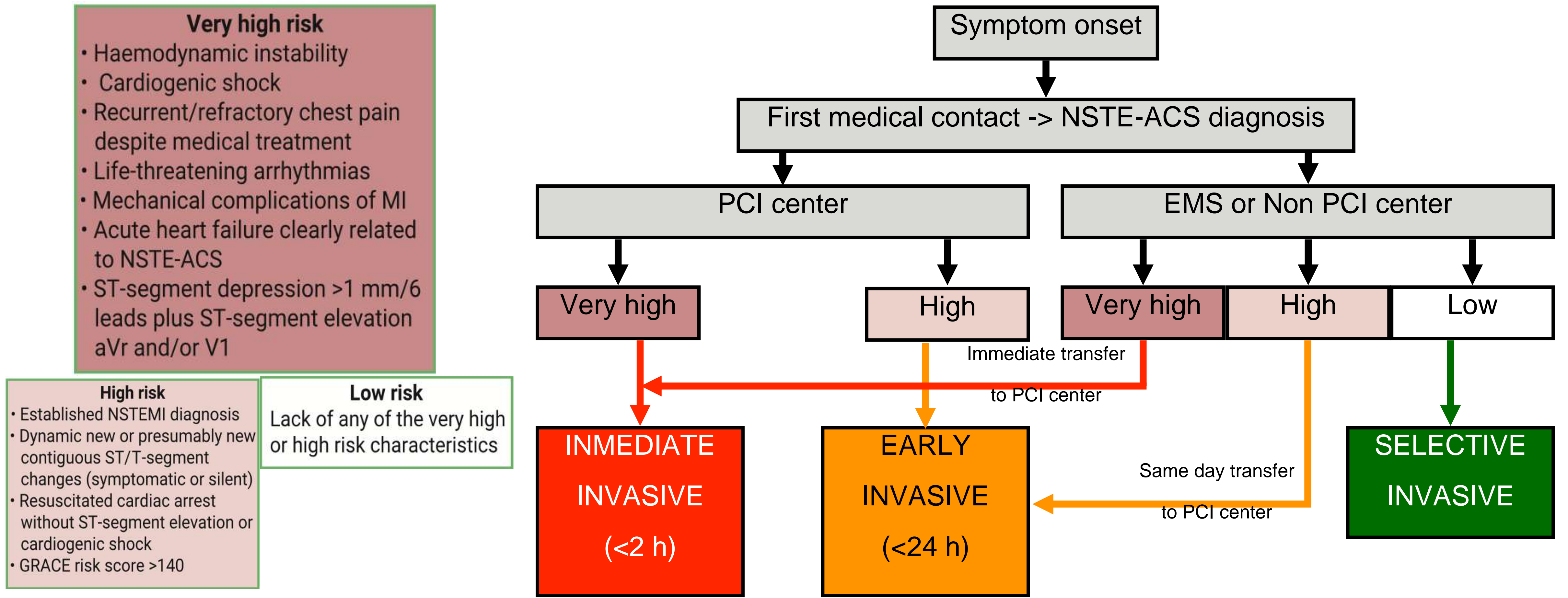
Recommendations for Coronary Angiography and Revascularization in Patients With NSTEMI-ACS

Referenced studies that support the recommendations are summarized in [Online Data Supplement 9](#).

COR	LOE	RECOMMENDATIONS
2a	B-R	4. In patients with NSTEMI-ACS who are initially stabilized and are at high risk of clinical events, it is reasonable to choose an early invasive strategy (within 24 hours) over a delayed invasive strategy to improve outcomes (11-16).
2a	B-R	5. In patients with NSTEMI-ACS who are initially stabilized and are at intermediate or low risk of clinical events, an invasive strategy with intent to perform revascularization is reasonable before hospital discharge to improve outcomes (11-16).
2a	B-NR	6. In patients with NSTEMI-ACS who have failed PCI and have ongoing ischemia, hemodynamic compromise, or threatened occlusion of an artery with substantial myocardium at risk, who are appropriate candidates for CABG, emergency CABG is reasonable (5-7,17).
3: Harm	B-R	7. In patients with NSTEMI-ACS who present in cardiogenic shock, routine multivessel PCI of non-culprit lesions in the same setting should not be performed (18,19).

Fuente: 1. J Am Coll Cardiol. 2022 Jan 18;79(2):e21-e129. doi: 10.1016/j.jacc.2021.09.006. Epub 2021 Dec 9.

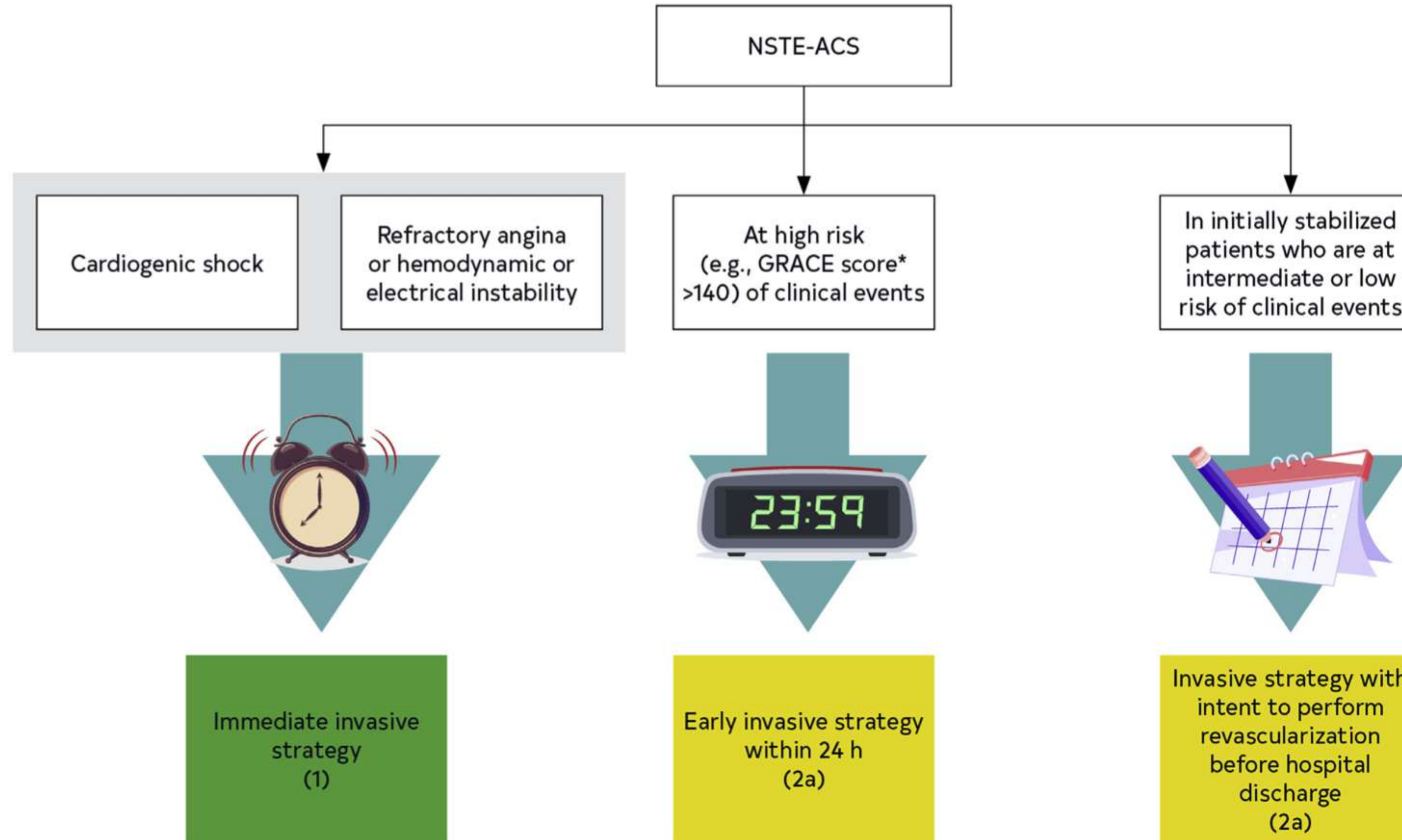
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1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Eur Heart J Acute Cardiovasc Care. 2020 Feb;9(1):76-89. doi: 10.1177/2048872619885346. Epub 2020 Jan 20.
3. Heart Vessels. 2016 Jun;31(6):897-906. doi: 10.1007/s00380-015-0695-8. Epub 2015 Jun 6.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?



Fuente: 1. J Am Coll Cardiol. 2022 Jan 18;79(2):e21-e129. doi: 10.1016/j.jacc.2021.09.006. Epub 2021 Dec 9.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Recommendations for coronary revascularization

Timing of invasive strategy

An immediate invasive strategy (<2 h) is recommended in patients with at least one of the following very high-risk criteria:

- Haemodynamic instability or CS.
- Recurrent or refractory chest pain despite medical treatment.
- Life-threatening arrhythmias.
- Mechanical complications of MI.
- Heart failure clearly related to NSTEMI-ACS.
- Presence of ST-segment depression >1 mm in ≥ 6 leads additional to ST-segment elevation in aVR and/or V1.

I

C

An early invasive strategy within 24 h is recommended in patients with any of the following high-risk criteria:

- Diagnosis of NSTEMI suggested by the diagnostic algorithm recommended in [section 3](#).
- Dynamic or presumably new contiguous ST/T-segment changes suggesting ongoing ischaemia.
- Transient ST-segment elevation.^{273,362}
- GRACE risk score >140.^{271,272,277}

I

A

A selective invasive strategy after appropriate ischaemia testing or detection of obstructive CAD by CCTA is recommended in patients considered at low risk.^{267,268,363}

I

A

Fuente:

1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Eur Heart J Acute Cardiovasc Care. 2020 Feb;9(1):76-89. doi: 10.1177/2048872619885346. Epub 2020 Jan 20.
3. Heart Vessels. 2016 Jun;31(6):897-906. doi: 10.1007/s00380-015-0695-8. Epub 2015 Jun 6.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Recommendations for non-ST-segment elevation acute coronary syndrome patients with heart failure or cardiogenic shock

Emergency coronary angiography is recommended in patients with CS complicating ACS. ^{205,416,417}	I	B
Emergency PCI of the culprit lesion is recommended for patients with CS due to NSTEMI-ACS, independent of the time delay from symptom onset, if the coronary anatomy is amenable to PCI. ^{205,417}	I	B
Emergency CABG is recommended for patients with CS if the coronary anatomy is not amenable to PCI. ^{205,417}	I	B
It is recommended to perform emergency echocardiography without delay to assess LV and valvular function and exclude mechanical complications.	I	C
In cases of haemodynamic instability, emergency surgical or catheter-based repair of mechanical complications of ACS is recommended, as decided by the Heart Team.	I	C
Routine use of IABP in patients with CS and no mechanical complications due to ACS is not recommended. ^{413,414,415}	III	B
Routine immediate revascularization of non-culprit lesions in NSTEMI-ACS patients with multivessel disease presenting with CS is not recommended. ^{346,408}	III	B

Fuente:

1. Eur Heart J. 2021 Apr 7;42(14):1289-1367. doi: 10.1093/eurheartj/ehaa575.
2. Eur Heart J Acute Cardiovasc Care. 2020 Feb;9(1):76-89. doi: 10.1177/2048872619885346. Epub 2020 Jan 20.
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¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Independent predictors of MACE: logistic regression analysis

Variables	Multivariate OR (95% CI)	Multivariate <i>p</i>
SS	0.915 (0.873–0.959)	<0.001
TIMI score	0.567 (0.346–0.931)	0.025
GRACE score	0.966 (0.942–0.991)	0.007
SS-II for PCI	1.146 (1.085–1.211)	<0.001
SS-II for CABG	1.053 (1.017–1.090)	0.004

Comparison of the Predictive Roles of Risk Scores of In-Hospital Major Adverse Cardiovascular Events in Patients with Non-ST Elevation Myocardial Infarction Undergoing Percutaneous Coronary Intervention

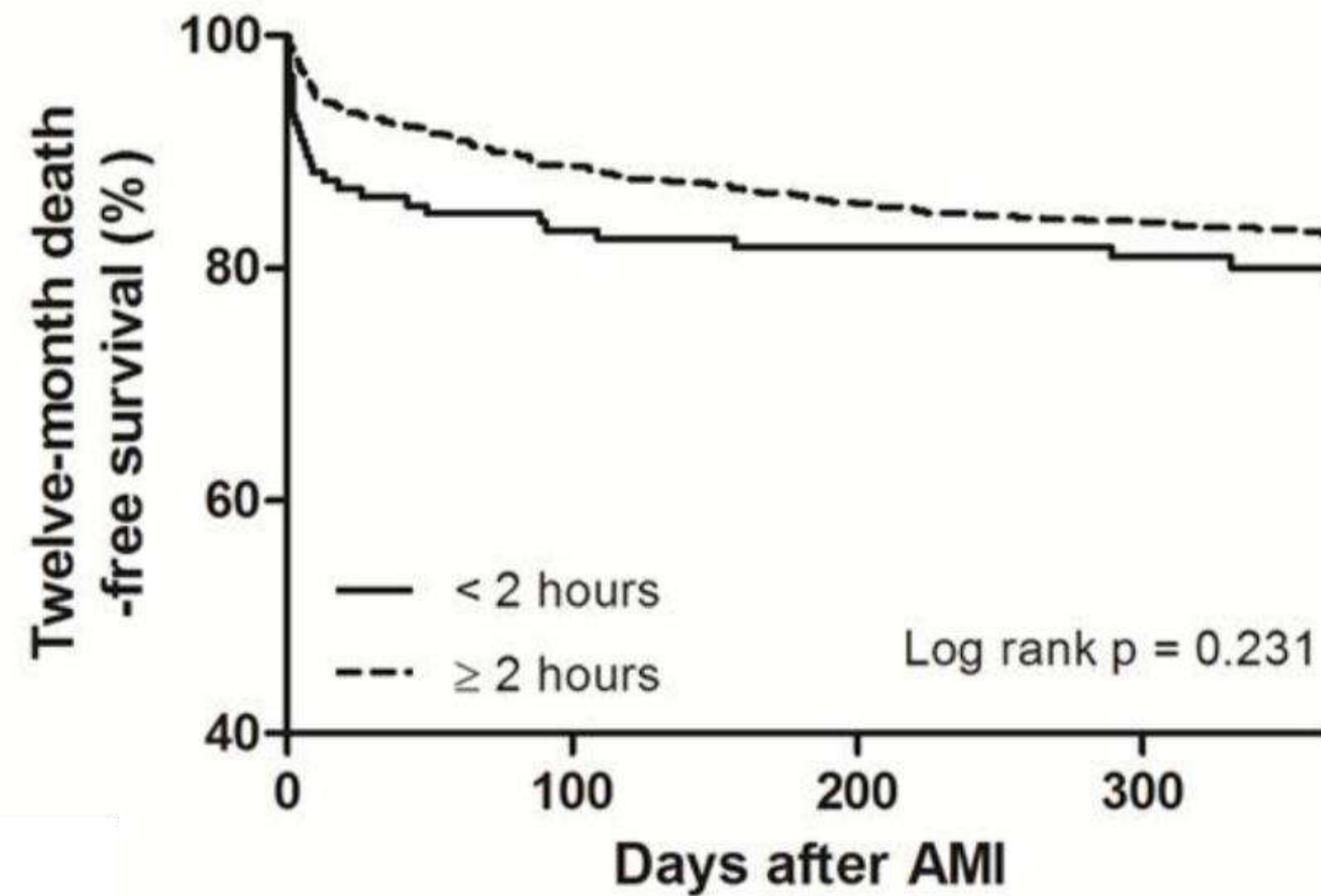
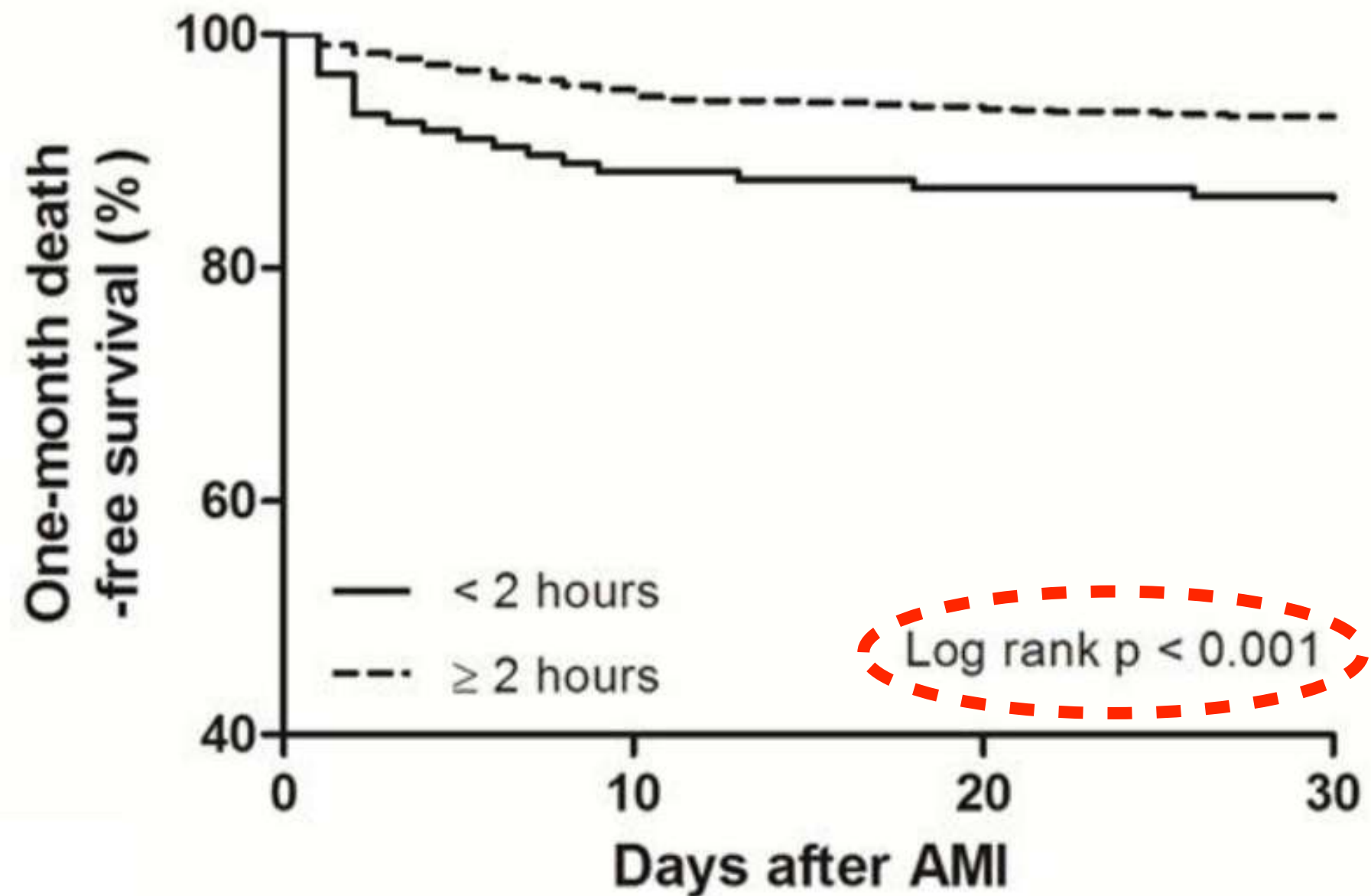
Erdal Aktürk, Lütfü Aşkın, Hakan Taşolar, Serdar Türkmen, Hakan Kaya

SS, SYNTAX score; CABG, coronary artery bypass graft; PCI, percutaneous coronary intervention.

Fuente: 1. Med Princ Pract. 2018;27(5):459-465. doi: 10.1159/000489399. Epub 2018 Apr 19.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Kaplan-Meier curves for 1-month, and 12-month death-free survival in patients who received PCI <2 vs. ≥ 2 hours after admission



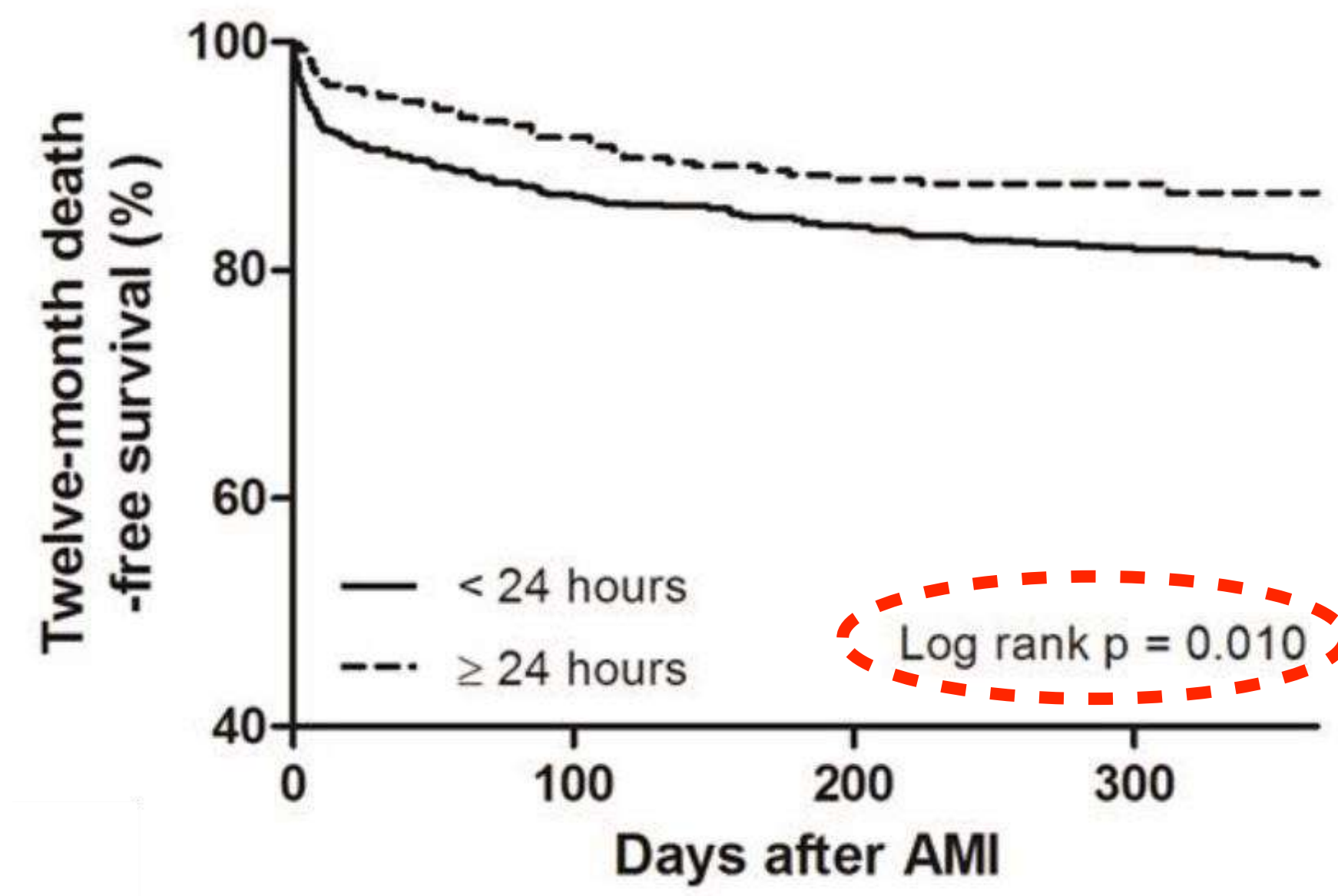
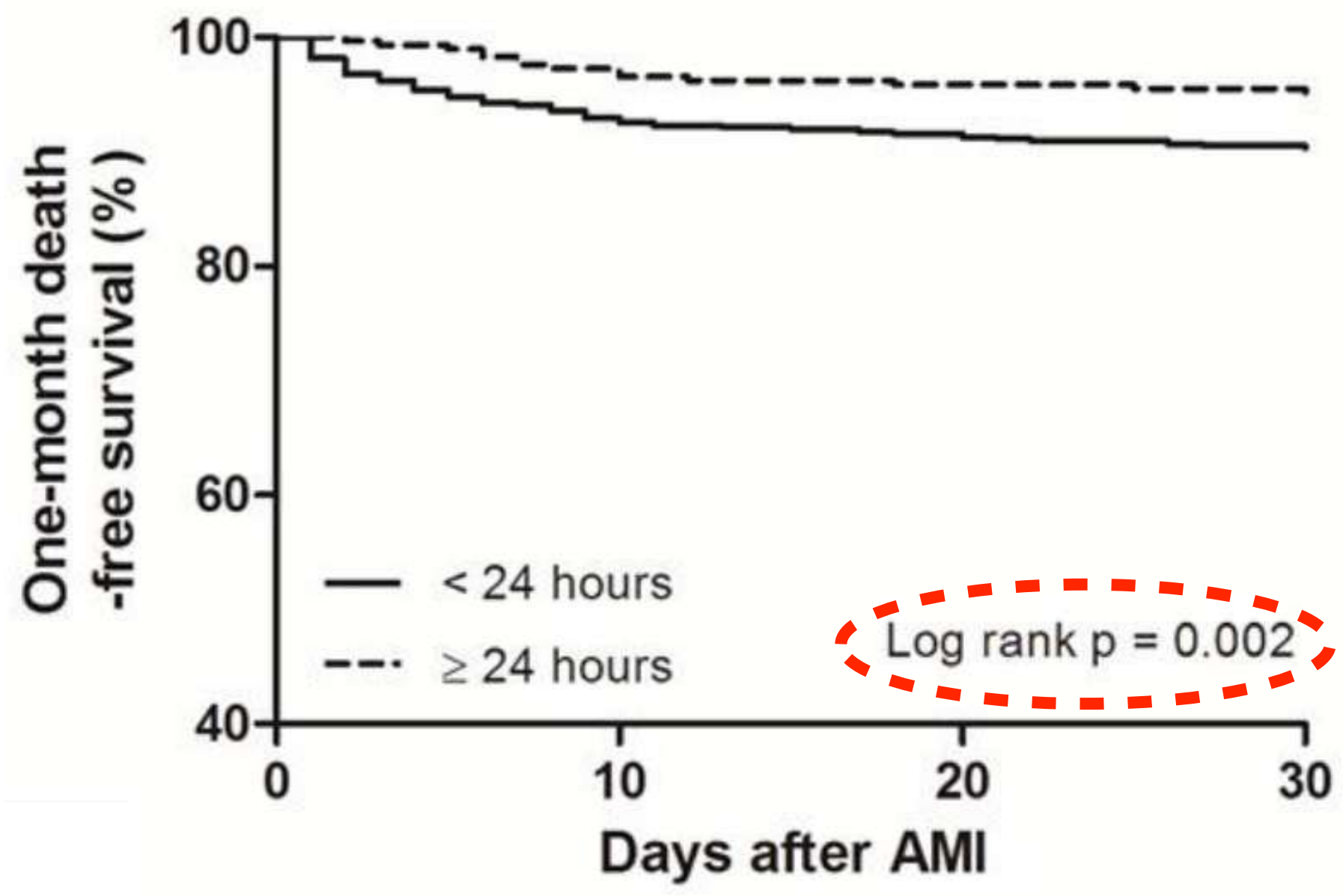
Optimal Timing of Percutaneous Coronary Intervention in Patients With Non-ST-Segment Elevation Myocardial Infarction Complicated by Acute Decompensated Heart Failure (from the Korea Acute Myocardial Infarction Registry–National Institutes of Health [KAMIR-NIH])

Min Chul Kim¹, Myung Ho Jeong², Doo Sun Sim¹, Young Joon Hong¹, Ju Han Kim¹, Youngkeun Ahn¹, Tae Hoon Ahn³, Ki Bae Seung⁴, Dong-Joo Choi⁵, Hyo-Soo Kim⁶, Hyeon Cheol Gwon⁷, In Whan Seong⁸, Kyung Kuk Hwang⁹, Shung Chull Chae¹⁰, Seung Ho Hur¹¹, Kwang Soo Cha¹², Seok Kyu Oh¹³, Jei Keon Chae¹⁴, KAMIR-NIH registry investigators

Fuente: 1. Am J Cardiol. 2018 Jun 1;121(11):1285-1292. doi: 10.1016/j.amjcard.2018.01.051. Epub 2018 Mar 1.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Kaplan-Meier curves for 1-month, and 12-month death-free survival in patients who received PCI 2 - 24 hours (< 24) vs. ≥ 24 hours after admission



Optimal Timing of Percutaneous Coronary Intervention in Patients With Non-ST-Segment Elevation Myocardial Infarction Complicated by Acute Decompensated Heart Failure (from the Korea Acute Myocardial Infarction Registry-National Institutes of Health [KAMIR-NIH])

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Fuente: 1. Am J Cardiol. 2018 Jun 1;121(11):1285-1292. doi: 10.1016/j.amjcard.2018.01.051. Epub 2018 Mar 1.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Clinical outcomes at 30 days and 12 months in stable high risk patients who went for EARLY PCI (<24 hours) or DELAYED PCI (>24 hours)

	[n (%)]		P-value
	Early PCI (N= 2210)	Delayed PCI (N= 2097)	
30-day outcomes			
Mortality	32 (1.4)	31 (1.5)	0.93
MI	41 (1.9)	53 (2.5)	0.13
TVR	36 (1.6)	42 (2.0)	0.36
MACE	94 (4.3)	104 (5.0)	0.27
In-hospital bleeding	37 (1.7)	44 (2.1)	0.31
12-month outcomes			
Mortality	73 (3.3)	97 (4.6)	0.02
MI	114 (5.2)	166 (7.9)	< 0.01
TVR	156 (7.1)	154 (7.3)	0.72
MACE	274 (12.4)	324 (15.5)	< 0.01

MACE, major adverse cardiovascular events; MI, myocardial infarction; PCI, percutaneous coronary intervention; TVR, target vessel revascularization.

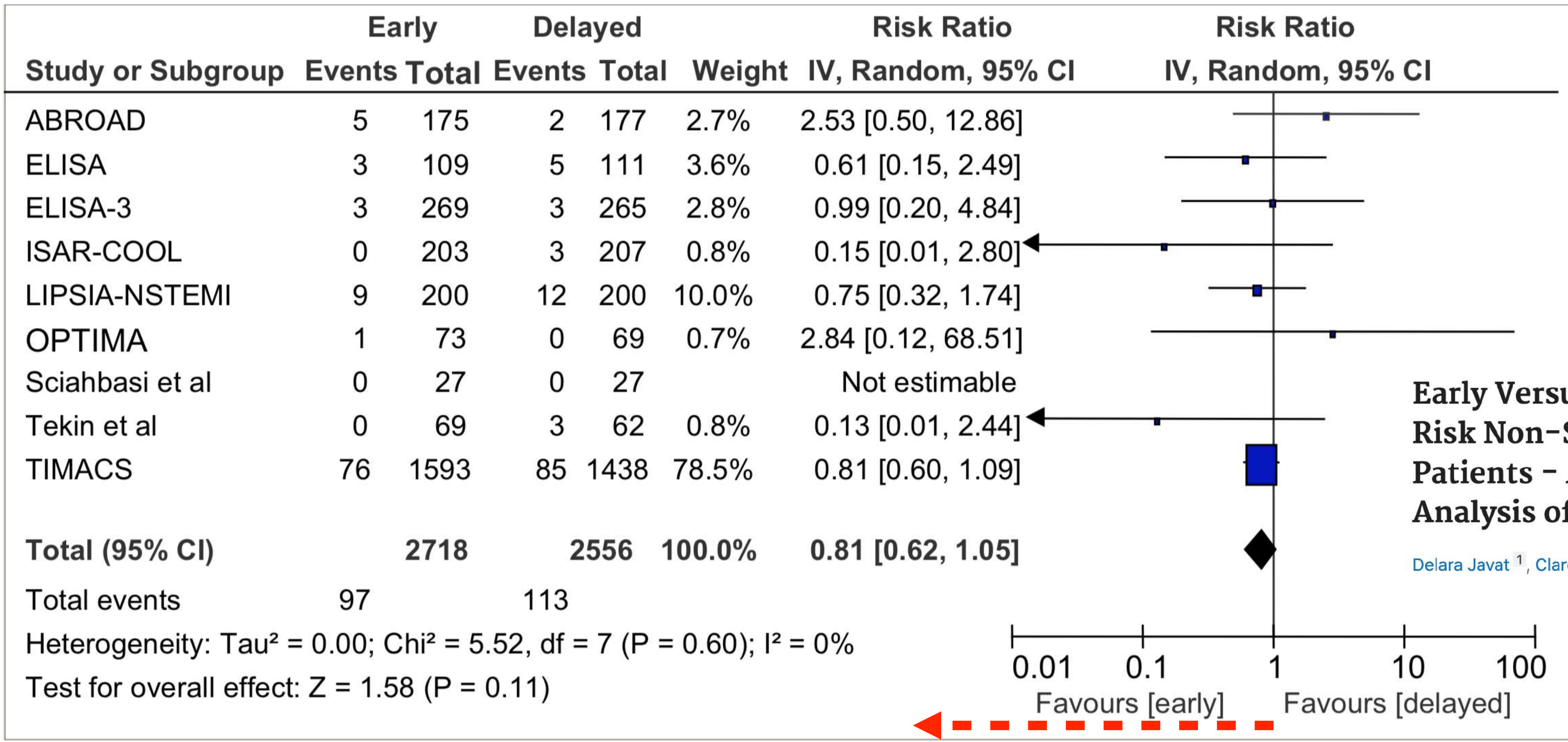
Early versus delayed percutaneous coronary intervention in patients with non-ST elevation acute coronary syndromes

Matias B Yudi ¹, Andrew E Ajani, Nick Andrianopoulos, Stephen J Duffy, Omar Farouque, Jay Ramchand, Ronen Gurvitch, Jeffrey Lefkovits, Melanie Freeman, Angela Brennan, David J Clark, Christopher Reid, David Eccleston, Melbourne Interventional Group

Fuente: 1. Coron Artery Dis. 2016 Aug;27(5):344-9. doi: 10.1097/MCA.0000000000000374.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Forest plot for early mortality



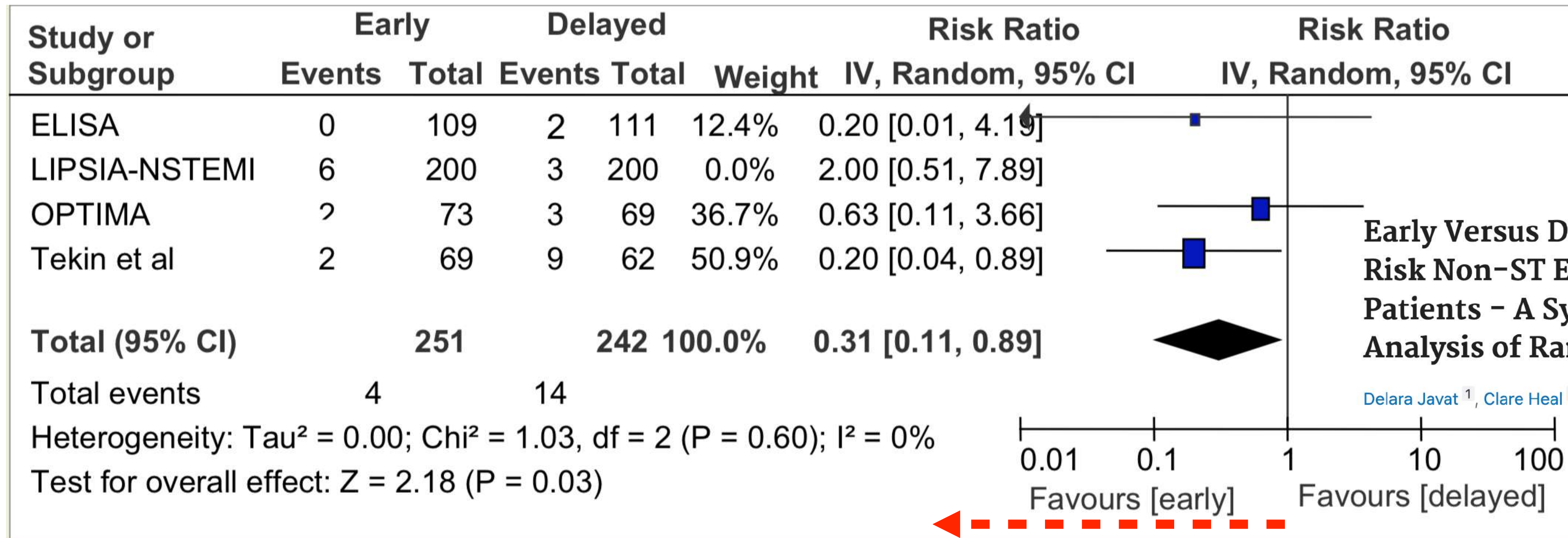
Early Versus Delayed Invasive Strategies in High-Risk Non-ST Elevation Acute Coronary Syndrome Patients - A Systematic Literature Review and Meta-Analysis of Randomised Controlled Trials

Delara Javat ¹, Clare Heal ², Stefan Buchholz ³, Zhihua Zhang ⁴

Fuente: 1. Heart Lung Circ. 2017 Nov;26(11):1142-1159. doi: 10.1016/j.hlc.2017.02.031. Epub 2017 Apr 11.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

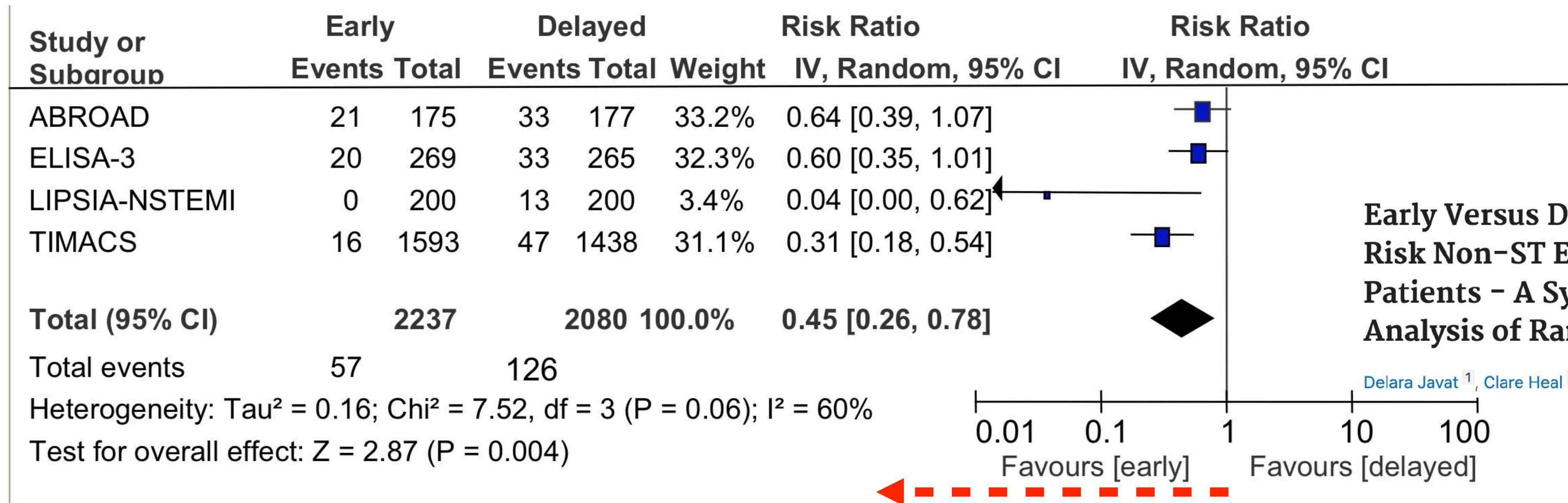
Forest plot for recurrent myocardial infarction



Fuente: 1. Heart Lung Circ. 2017 Nov;26(11):1142-1159. doi: 10.1016/j.hlc.2017.02.031. Epub 2017 Apr 11.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Forest plot for recurrent ischaemia



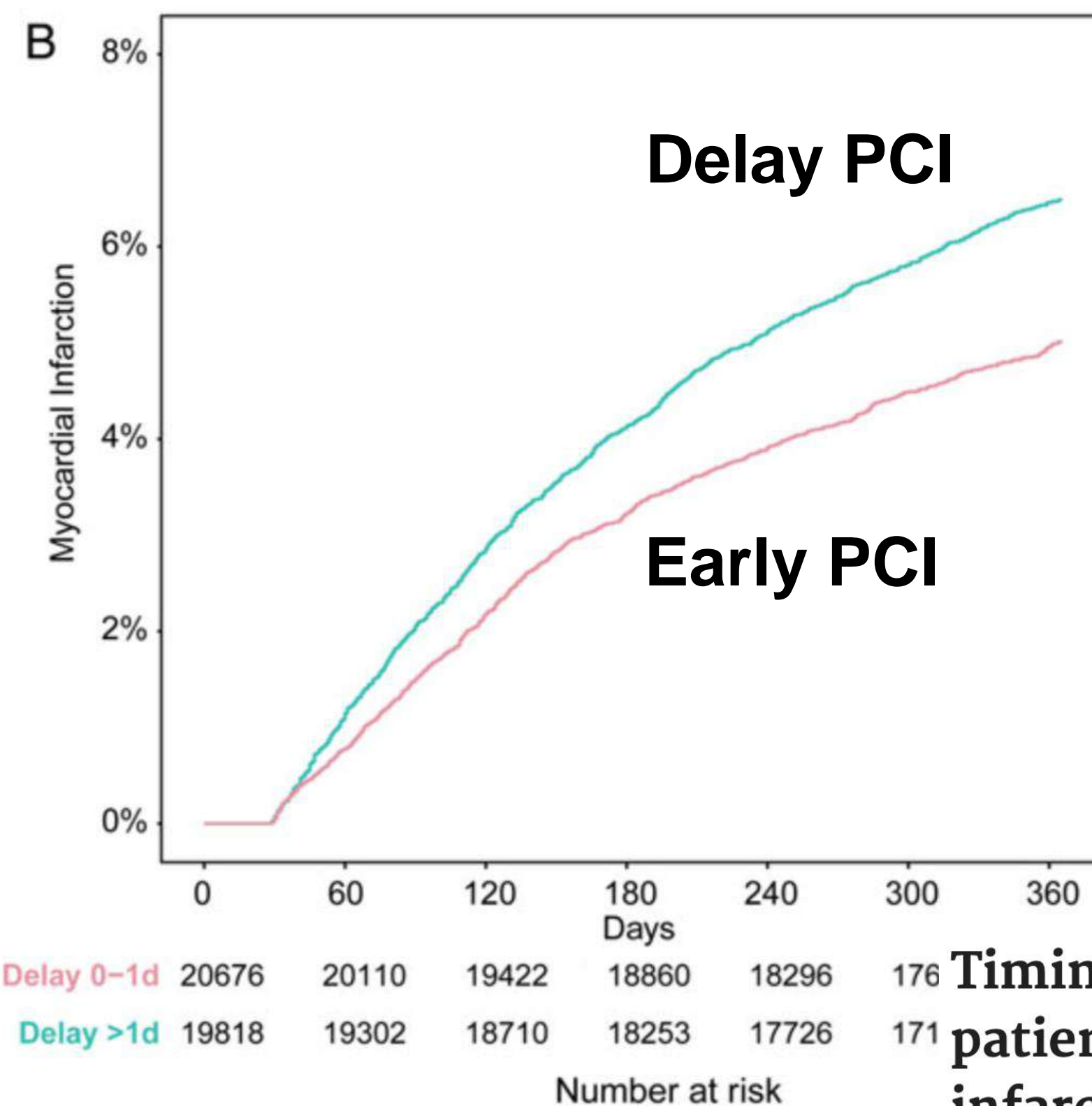
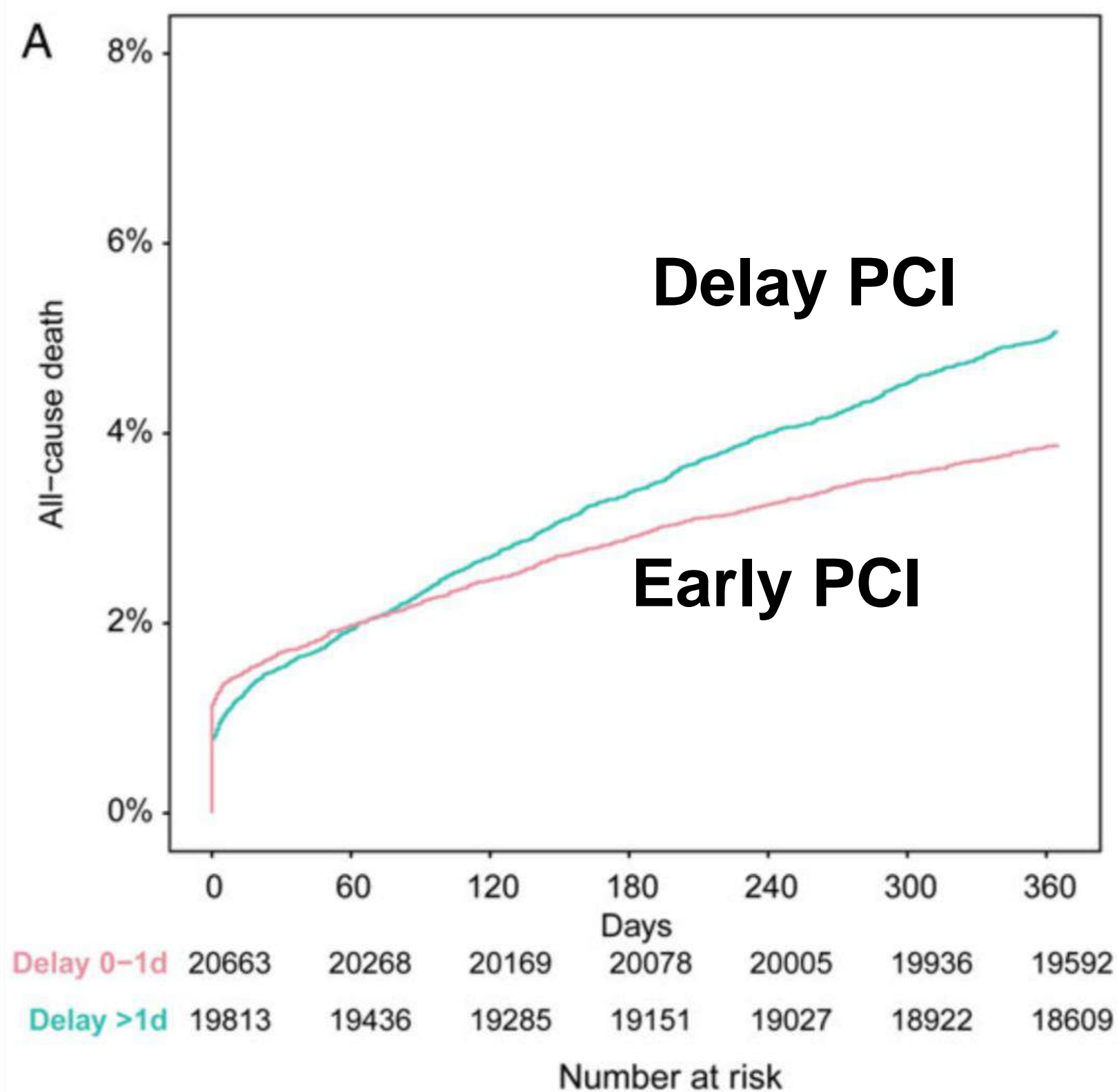
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Delara Javat¹, Clare Heal², Stefan Buchholz³, Zhihua Zhang⁴

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¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

One-day cut-off—Outcomes for All-cause death (A) and Myocardial infarction (B)



Timing of percutaneous coronary intervention in patients with non-ST-elevation myocardial infarction: a SWEDEHEART study

Daniel Lindholm^{1 2}, Joakim Alfredsson³, Oskar Angerås⁴, Felix Böhm⁵, Fredrik Calais⁶, Sasha Koul⁷, Bo Lagerqvist^{1 2}, Henrik Renlund², Giovanna Sarno^{1 2}, Christoph Varenhorst^{1 2}

Fuente: 1. Eur Heart J Qual Care Clin Outcomes. 2017 Jan 1;3(1):53-60. doi: 10.1093/ehjqcc/qcw044.

¿CUÁNDO DEBEMOS INDICAR Y/O REALIZAR EL INTERVENCIONISMO CORONARIO?

Outcomes at 1 year in relation to delay of percutaneous coronary intervention procedure

Endpoint	Early PCI		Delayed PCI		Unadj HR (95% CI)	Adjusted HR (95% CI)	P-value
All-cause death, 1-day cut-off	801/20 676	(3.9%)	1004/19 818	(5.1%)	0.75 (0.71–0.79)	0.89 (0.80–0.98)	0.018
All-cause death, 2-day cut-off	1083/28 502	(3.8%)	722/11 992	(6.0%)	0.67 (0.64–0.71)	0.78 (0.71–0.86)	<0.001
All-cause death, 3-day cut-off	12993/33 087	(3.9%)	506/7407	(6.8%)	0.62 (0.59–0.66)	0.75 (0.68–0.84)	<0.001
MI, 1-day cut-off	984/20 676	(5%)	1239/19 818	(6.5%)	0.83 (0.79–0.88)	0.95 (0.87–1.03)	0.23
MI, 2-day cut-off	1399/28 502	(5.2%)	824/11 992	(7.1%)	0.78 (0.74–0.83)	0.88 (0.81–0.96)	0.0055
MI, 3-day cut-off	1662/33 087	(5.3%)	561/7407	(7.8%)	0.75 (0.70–0.80)	0.86 (0.78–0.95)	0.0030
Stent thrombosis, 1-day cut-off	129/20 541	(0.6%)	139/19 680	(0.7%)	1.00 (0.83–1.21)	0.89 (0.70–1.14)	0.37
Stent thrombosis, 2-day cut-off	182/28 323	(0.7%)	86/11 898	(0.7%)	1.02 (0.83–1.25)	0.90 (0.69–1.16)	0.41
Stent thrombosis, 3-day cut-off	208/32 872	(0.6%)	60/7349	(0.8%)	0.94 (0.75–1.19)	0.79 (0.59–1.06)	0.11

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CONCLUSIONES

- Un diagnóstico precoz y una estratificación de riesgo oportuna nos permitirán tener los mejores resultados tanto a corto como largo plazo.
- En el SCASEST, el beneficio de la estrategia invasiva se centra fundamentalmente en identificar, a través de una adecuada estratificación de riesgo, que paciente se beneficia más de un intervencionismo oportuno.
- Por ello, la pregunta que debemos responder en este tipo de patologías no es si la estrategia invasiva es para todos, sino:
 - ¿Cuándo obtendré los mejores resultados para mi paciente, con una estrategia invasiva?

2022

gracias



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