Speaker's name: Thomas Cuisset, MD, PhD

X **I have the following potential conflicts of interest to report:**

Consulting and/or lecture fees: Abbott Vascular, Astra Zeneca, Boston Scientific, Crossroad Institute, Edwards, Europa Organisation, Medtronic, Terumo, Sanofi

2019 ESC Guidelines on the diagnosis and management of chronic coronary syndromes

« Messages clés »

Thomas CUISSET
CHU Timone, Marseille

ESC
European Society of Cardiology

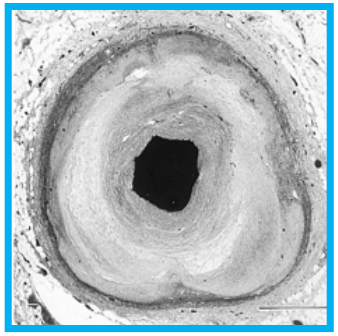
2006
Stable Angina

2013
Stable Coronary artery disease

2019
Chronic coronary syndromes

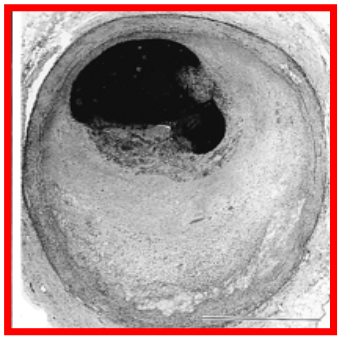
One disease, two presentations

Chronic coronary syndrome



Planned patient
Outpatient clinic
Non invasive testing
Risk = long term mortality

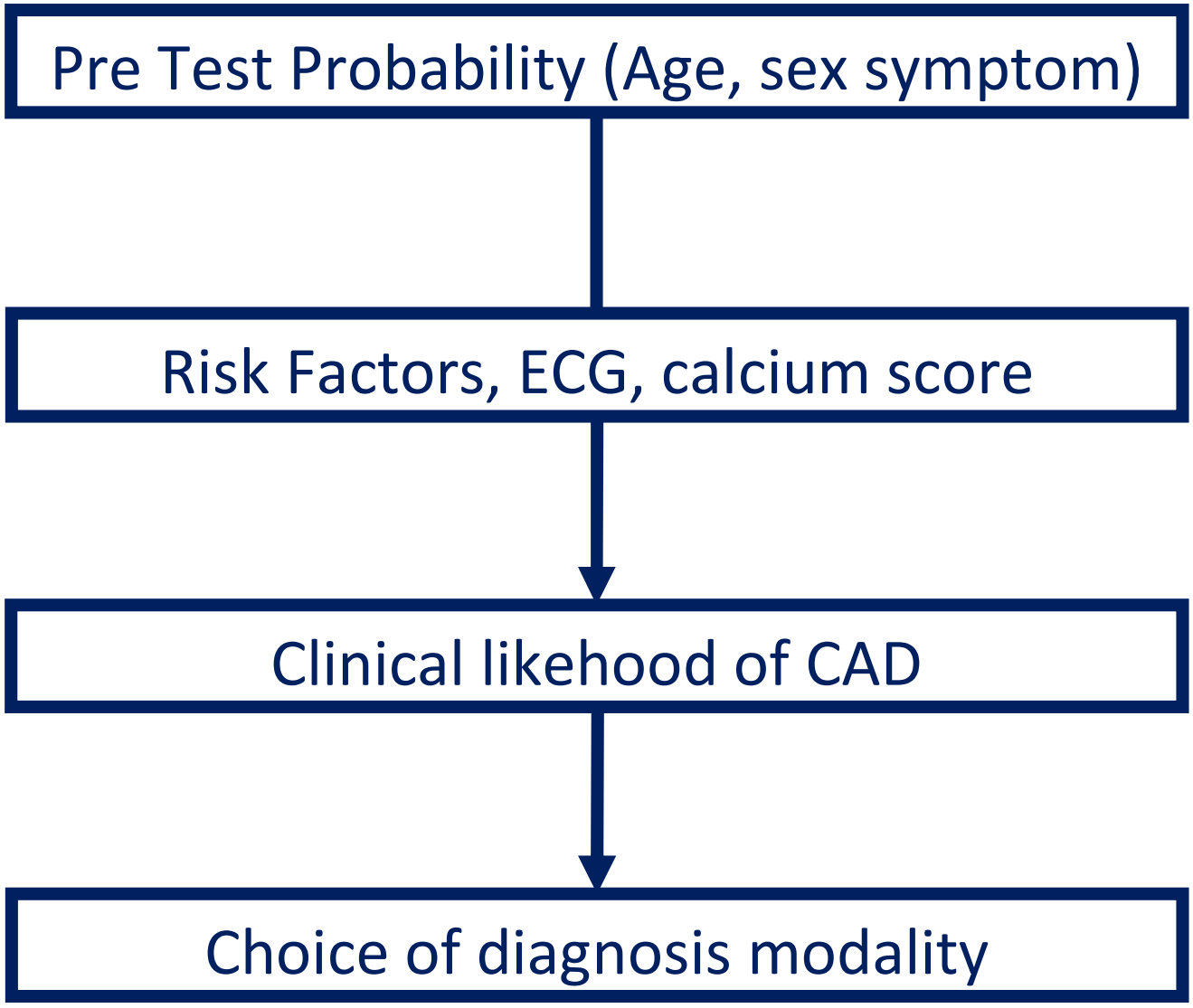
Acute Coronary Syndrome



Urgent admission
Hospitalisation
Coronary angiography
Risk = short term mortality

ESC Guidelines on the diagnosis and management of chronic coronary syndromes
(European Heart Journal 2019; 10.1093/eurheartj/ehz425)

Diagnosis of CCS



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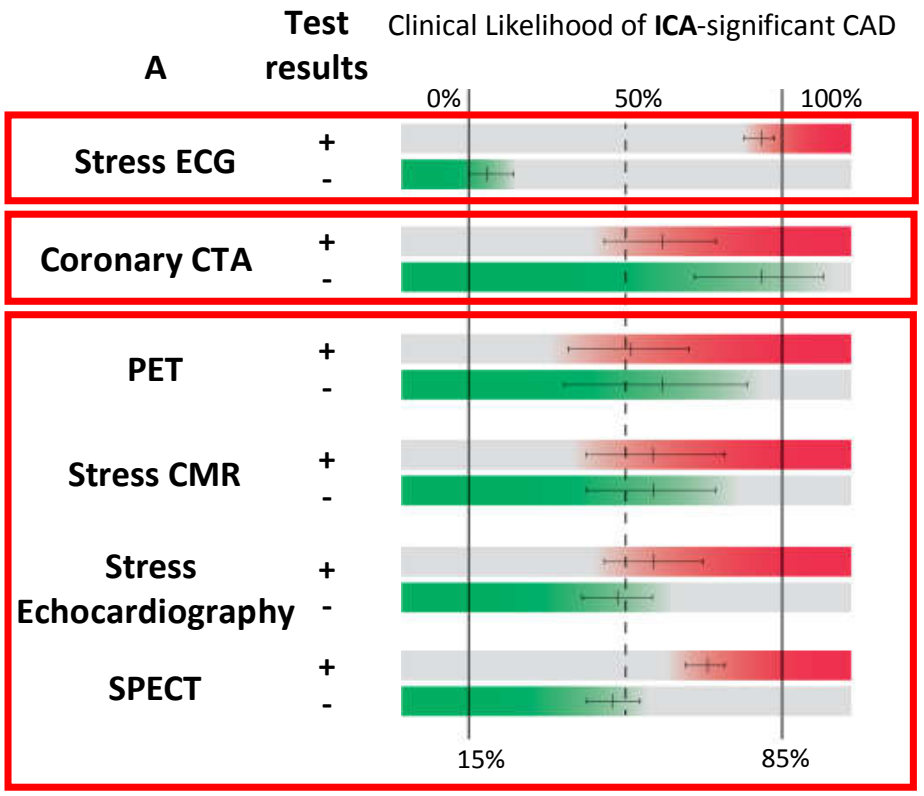
Performance of Tests



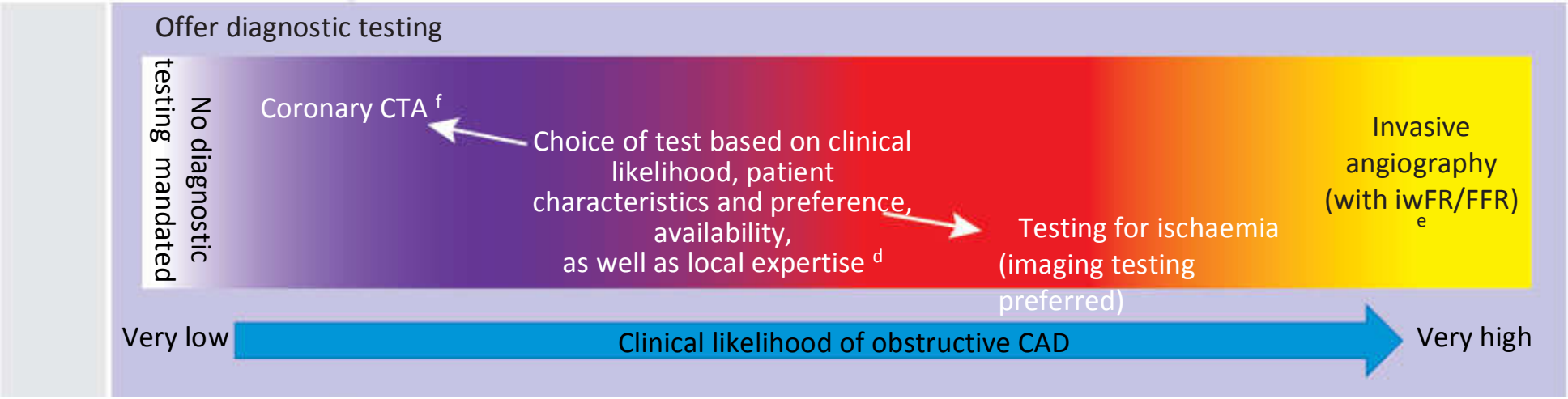
Ranges of clinical likelihood for rule-in/out CAD

85%

Clinical Likelihood range where test can **rule-in** CAD (Post-test probability will rise above 85%)

Clinical Likelihood range where test can **rule-out** CAD (Post-test probability will drop below 15%)

Choice of test for each patient



Management of Chronic coronary syndrome

Management of Symptom

‘Angina’

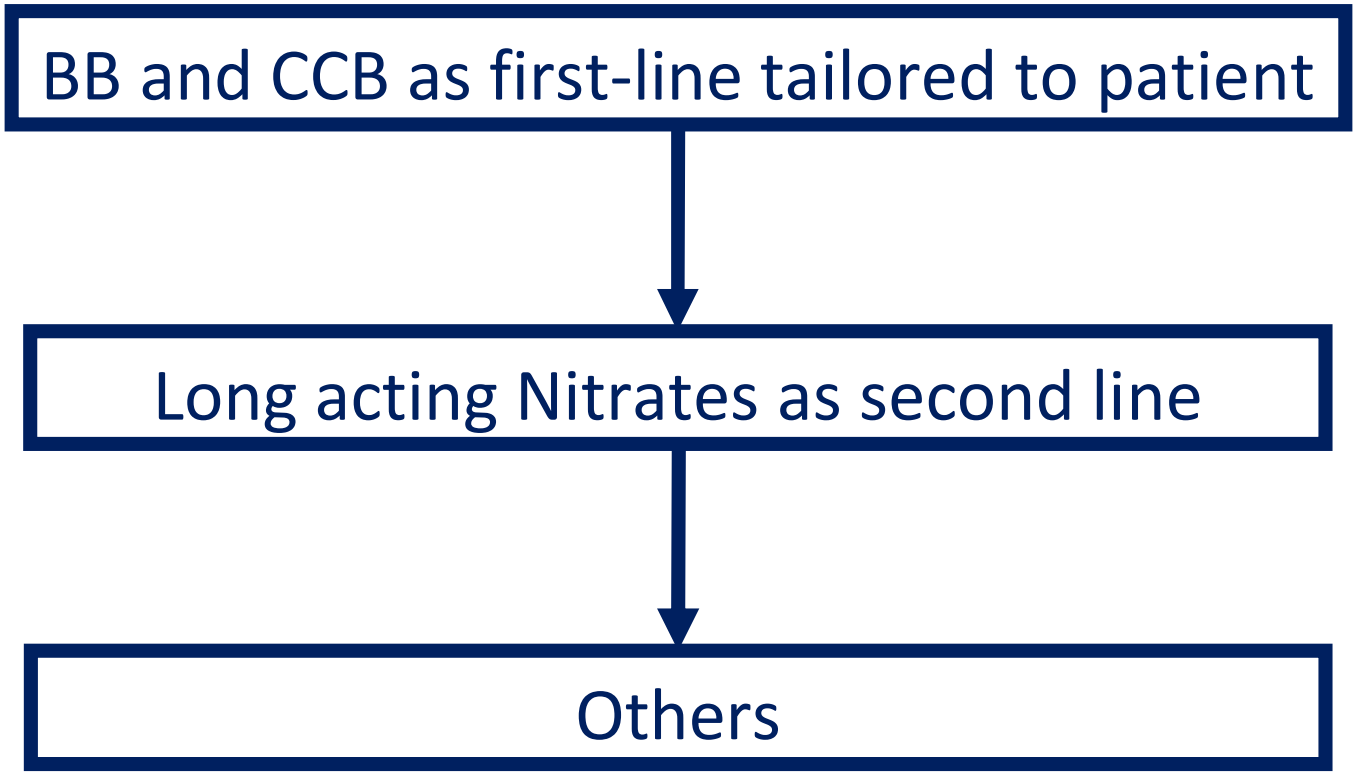
Anti-ischemic drug
Revascularisation

Management of CAD

‘Event prevention’

Prevention
Life style
Medications

Anti-ischemic drugs



Antithrombotic Strategy

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DAPT for CCS

When to do « less »?

No Antiplatelet drug if OAC indication

OAC + APLT drug in selected pt (IIb)

Standard

ASA lifelong (IA)

Or Clopidogrel

If ASA intolerance (Ia)

If prior PAD / Stroke (IIb)

When to do « more » ?

Optimized antithrombotic strategy

ASA + Second Drug

High Risk patient (IIa)

Intermediate risk (IIb)

DAPT after DES for CCS

When to do « less »?

Shorter duration

3 Mo in HBR patients **(IIa)**

1 Mo in very HBR patients **(IIb)**

Standard post PCI

ASA + Clopidogrel (IA)

Duration = 6 Mo (IA)

When to do « more » ?

Early Potent P2Y12 blockers

Ticagrelor or Prasugrel **(IIb)**

In High risk patients / PCI

Followed by de-escalation

Longer duration

> 6 Mo in High risk patients **(IIa)**

DAPT after DES for CCS with OAC

When to do « less »?

High Bleeding risk

Shorter Triple therapy (IIa)

Reduced Dose of NOAC (IIa)

Dabigatran, Rivaroxaban

Standard post PCI

Triple therapy

Full dose NOAC (I)

ASA + Clopidogrel (I)

1 Month (I)

When to do « more » ?

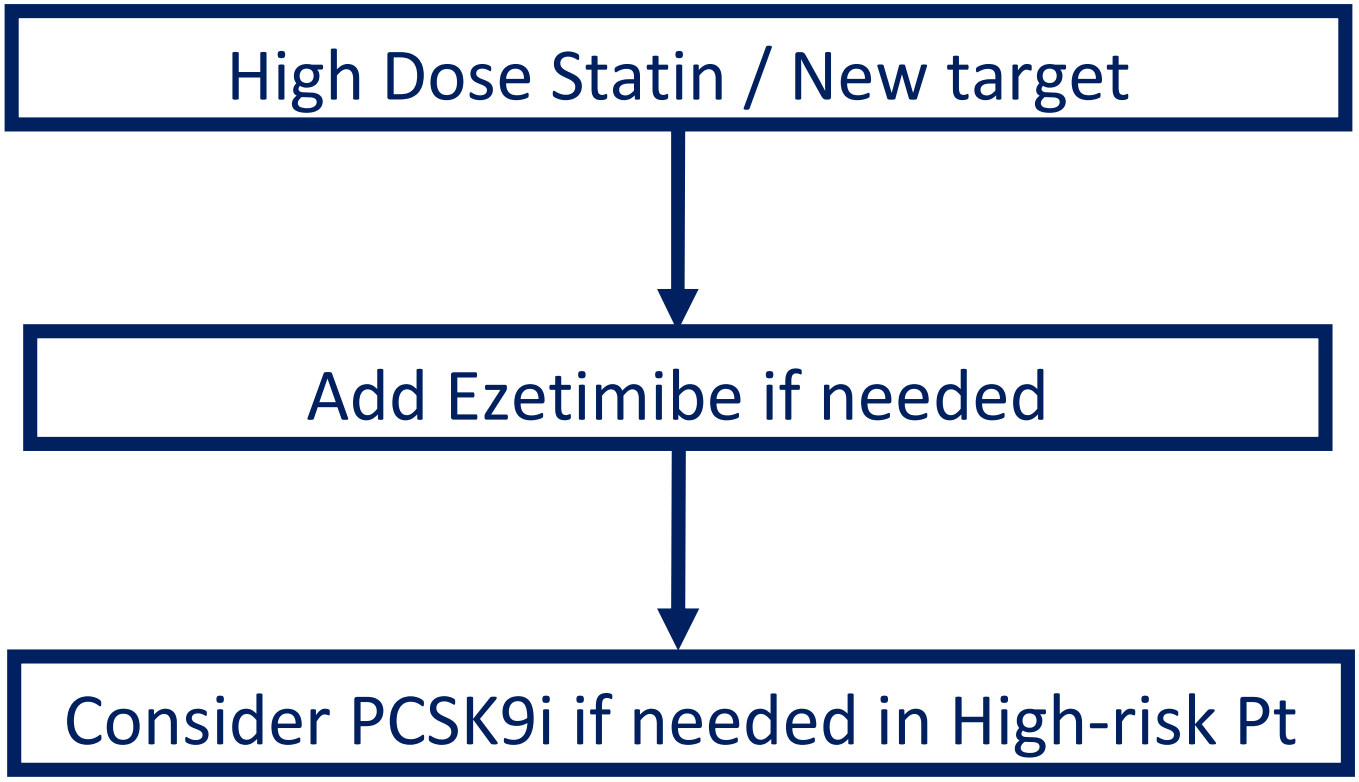
High ischemic risk

Longer triple therapy up to 6 Mo (IIa)

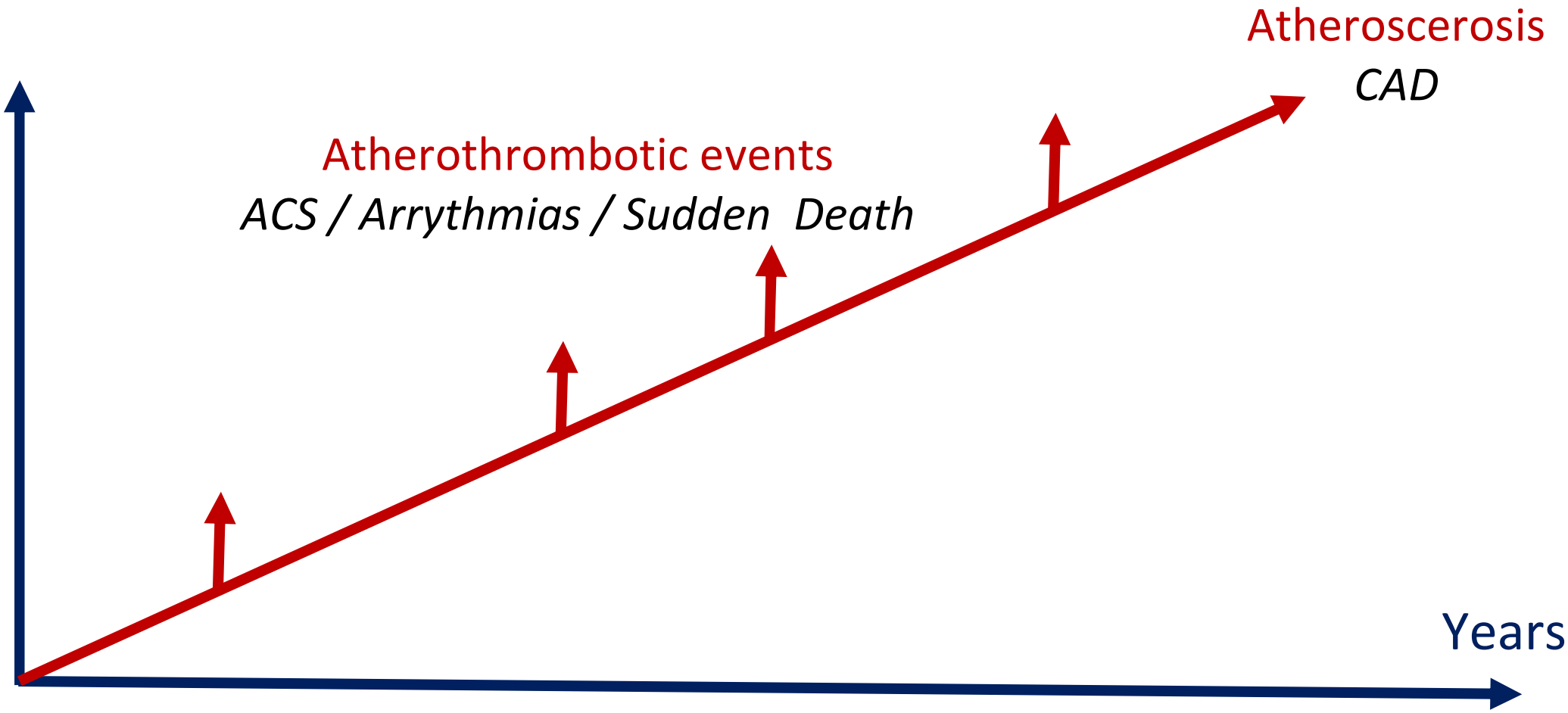
Dual therapy

OAC + Tica / Prasu (IIb)

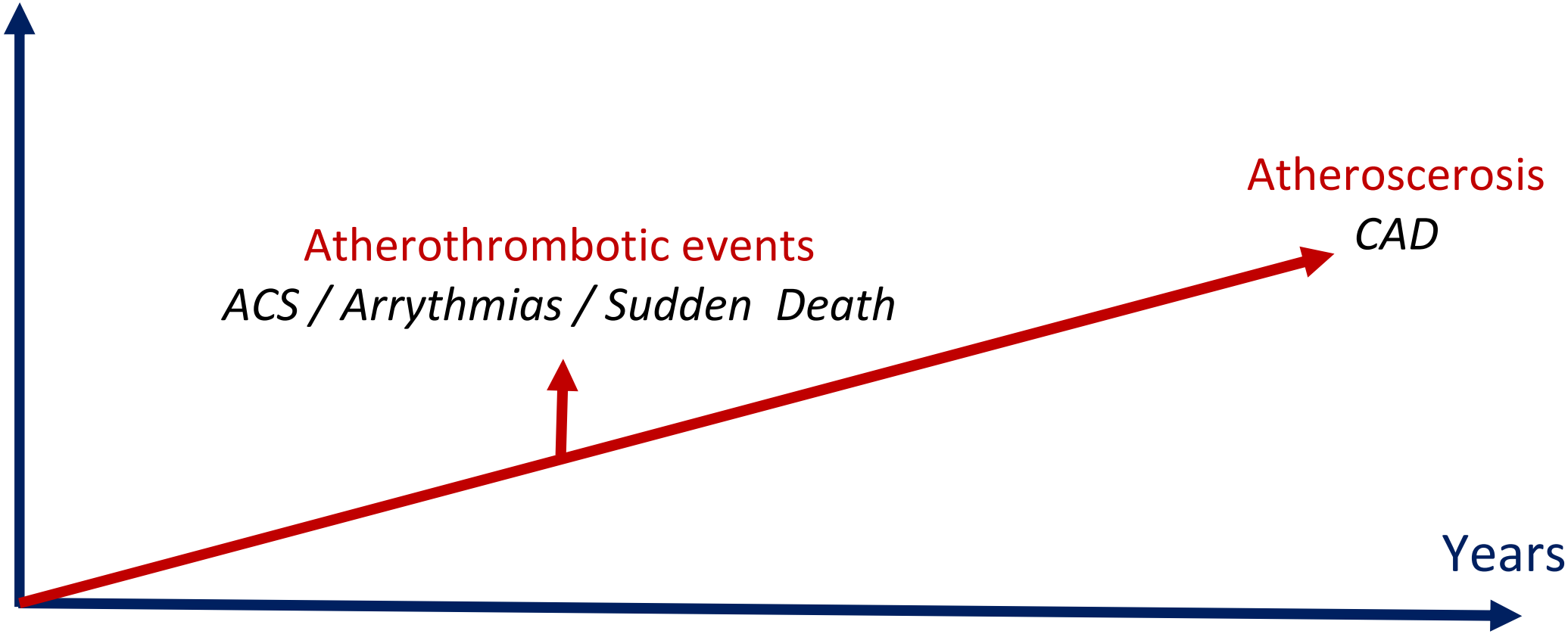
Lipid-lowering drugs



Poor Secondary Event Prevention



Good Secondary Event Prevention



Revascularisation in CCS

No Major change from earlier guidelines

Revascularisation based on symptom / ischemia

Value of FFR if stenosis < 90% and No ischemia

No Major change after ISCHEMIA trial ?

Messages clés

New title = Chronic coronary syndrome
Screening: more CT / Less stress ECG / based on PTP
Anti-ischemic drugs: BB and CCB / Nitrates as second line
Event prevention
Life style recommendations
Optimized antithrombotic strategy in high-risk patients
Optimized lipid-lowering therapy in high-risk patients
Revascularisation for symptom +/- prognosis in high-risk pt
Follow-up yearly
…. And …

Optimized event prevention in high risk patient

Optimized Antithrombotic strategy (IIaA recommendation)

Ticagrelor 60 mg (PEGASUS): No reimbursement

Rivaroxaban 2,5 mg (COMPASS): No reimbursement

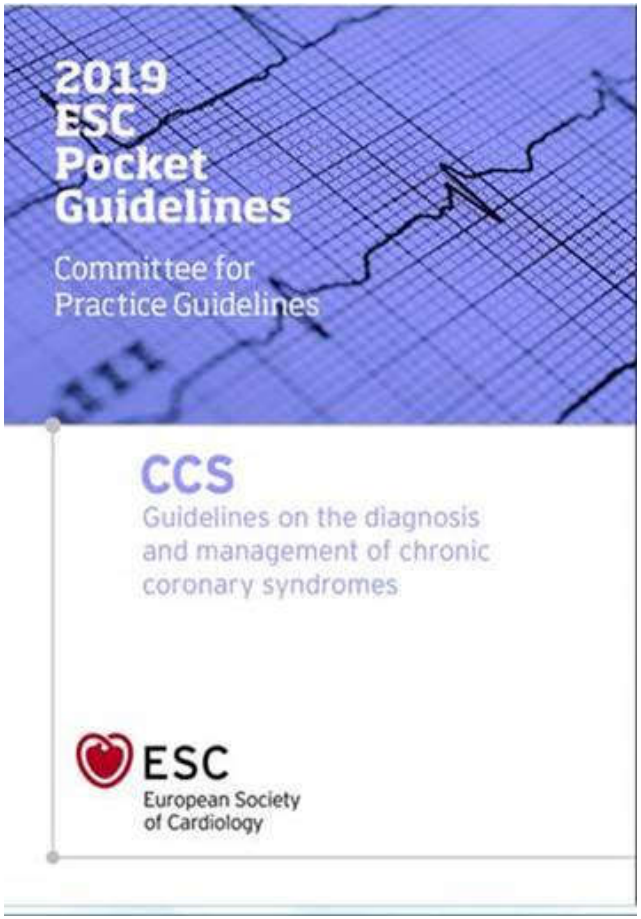
Optimized lipid-lowering therapy (IA recommendation)

AntiPCSK9 = class IA in high-risk patient (FOURRIER, ODYSSEY): ASMR 5

How to apply guidelines with local constraint ?

www.escardio.org/guidelines

Full Text
ESC Pocket Guidelines App
and much more…



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