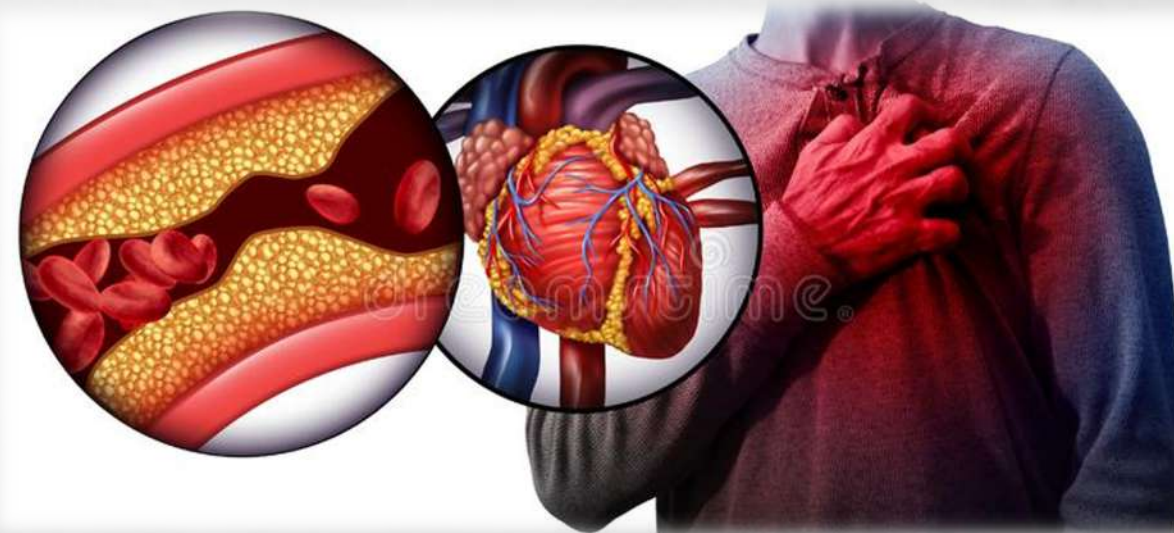




**SESARAM** E.P.E.  
Serviço de Saúde da RAM E.P.E.

# **TERAPÊUTICA ANTIAGREGANTE NA DOENÇA CORONÁRIA**

## ***NOVOS DESAFIOS***



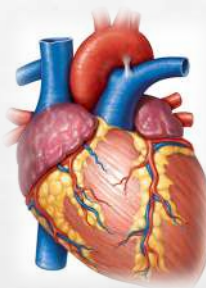
**Orientador: Dr. Gomes Serrão**  
**Diretor de Serviço: Dr. Drumond Freitas**

***Serviço de Cardiologia***

**MARGARIDA TEMTEM**

***8 de abril 2021***

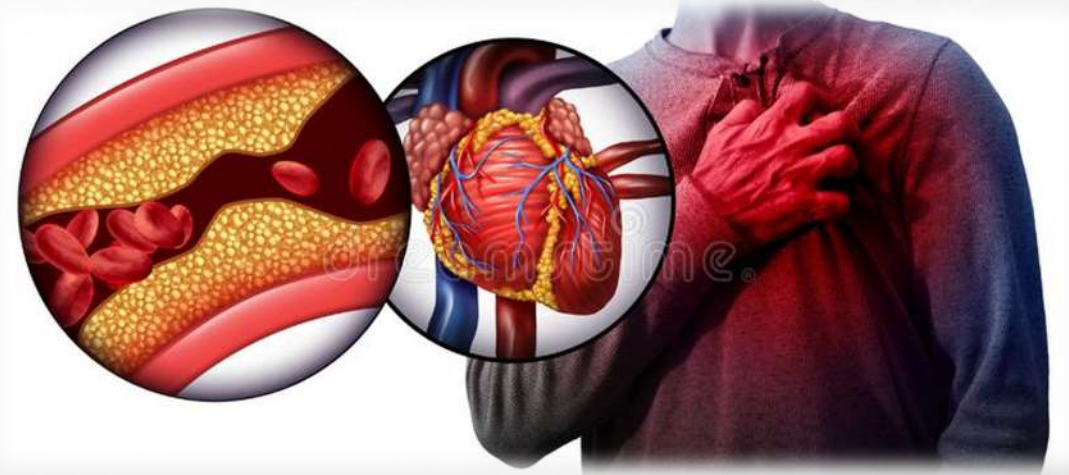
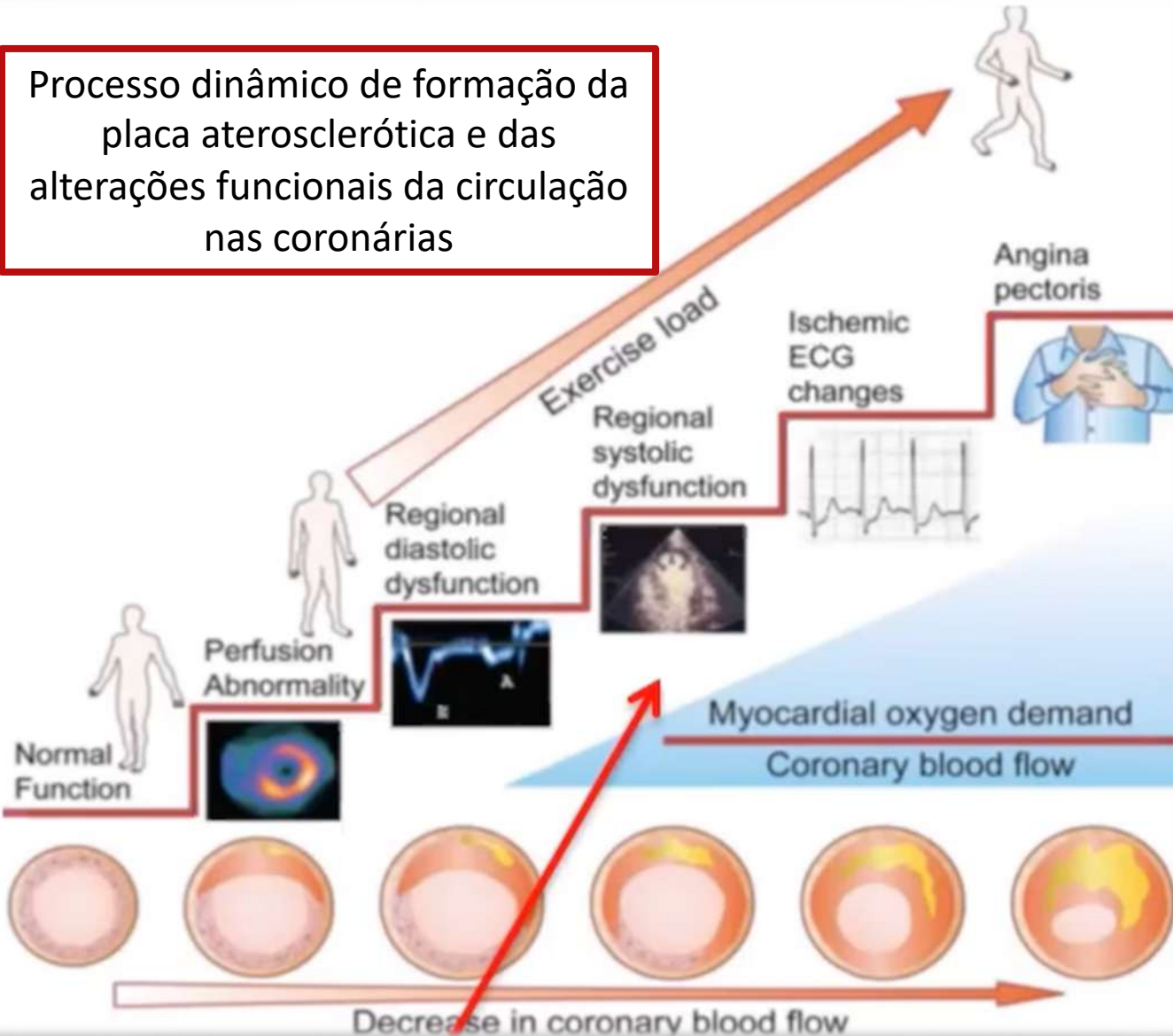
# Índice



- EVOLUÇÃO DA DOENÇA ARTERIAL CORONÁRIA
- INTRODUÇÃO À TERAPÊUTICA ANTIAGREGANTE PLAQUETÁRIA DUPLA (DAPT)
- DAPT NO SÍNDROME CORONÁRIO AGUDO
- DAPT NO SÍNDROME CORONÁRIO CRÔNICO
- DAPT EM POPULAÇÕES ESPECIAIS
  - FA
  - PRÉ-OPERATÓRIO
- MENSAGENS CHAVE

# Introdução

Processo dinâmico de formação da placa aterosclerótica e das alterações funcionais da circulação nas coronárias

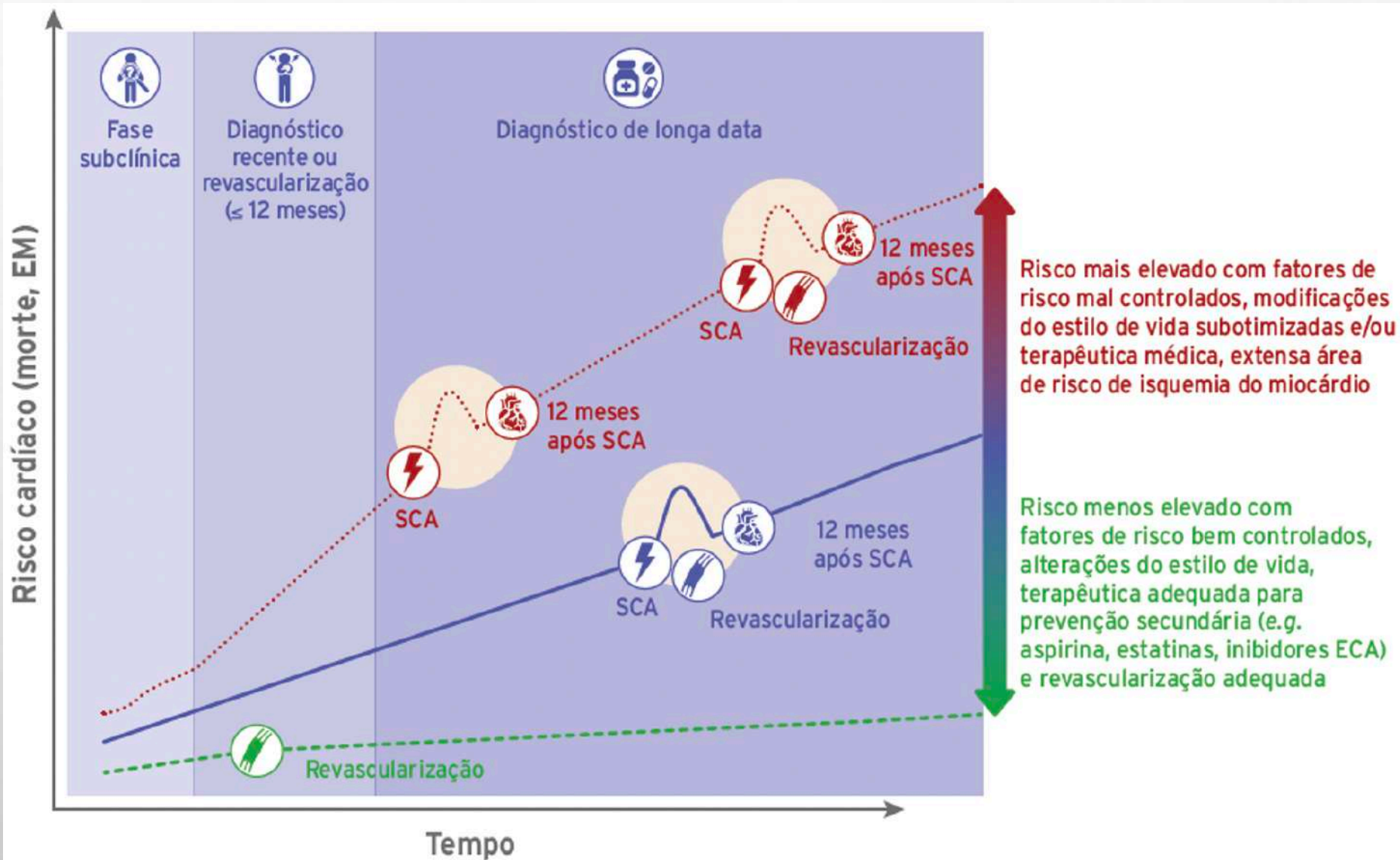


Cardiopatia Isquémica é a **causa isolada mais comum de morte**, apesar da redução assistida nas últimas décadas:



- Maior utilização da **terapêutica de reperfusão**
- **Terapêutica antitrombótica moderna**
- **Prevenção secundária**

# História Natural da DAC

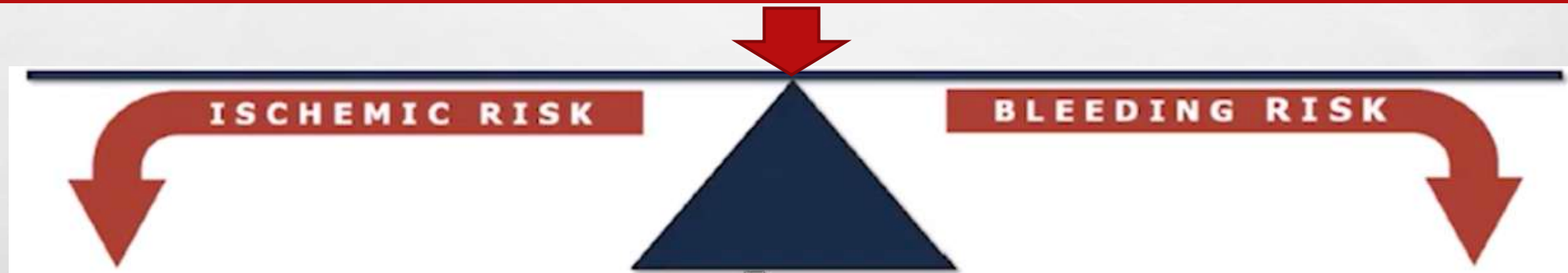


Nas Recomendações atuais cada capítulo trata dos principais cenários clínicos das Síndromes Coronárias Crônicas. Esta estrutura visa simplificar a utilização destas Recomendações na prática clínica.  
ECA = enzima de conversão da angiotensina; EM = enfarte do miocárdio; SCA = síndromes coronárias agudas.

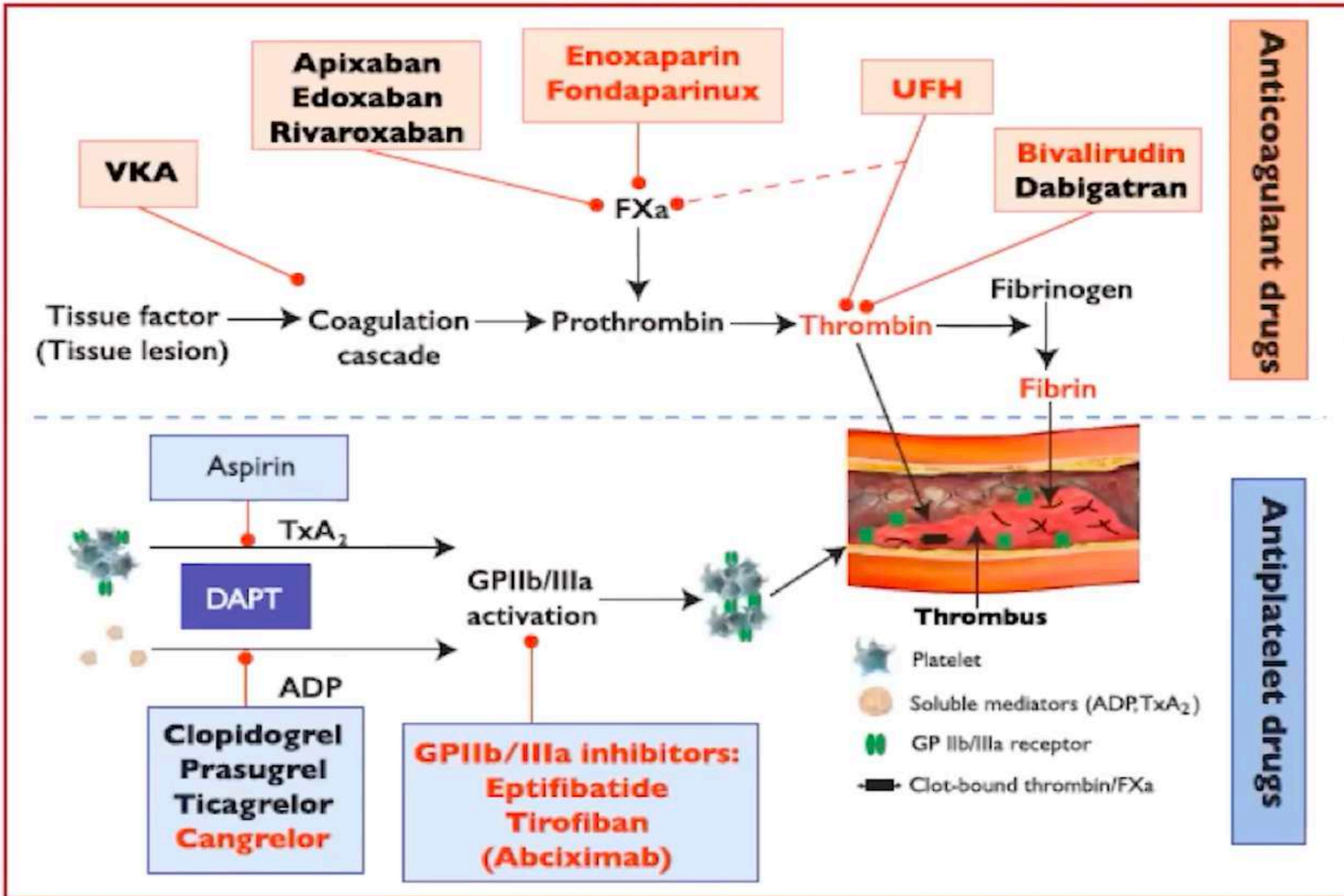
# Terapêutica Antiagregante da DAC

→ A Terapêutica Antiagregante na DAC está em constante mudança;

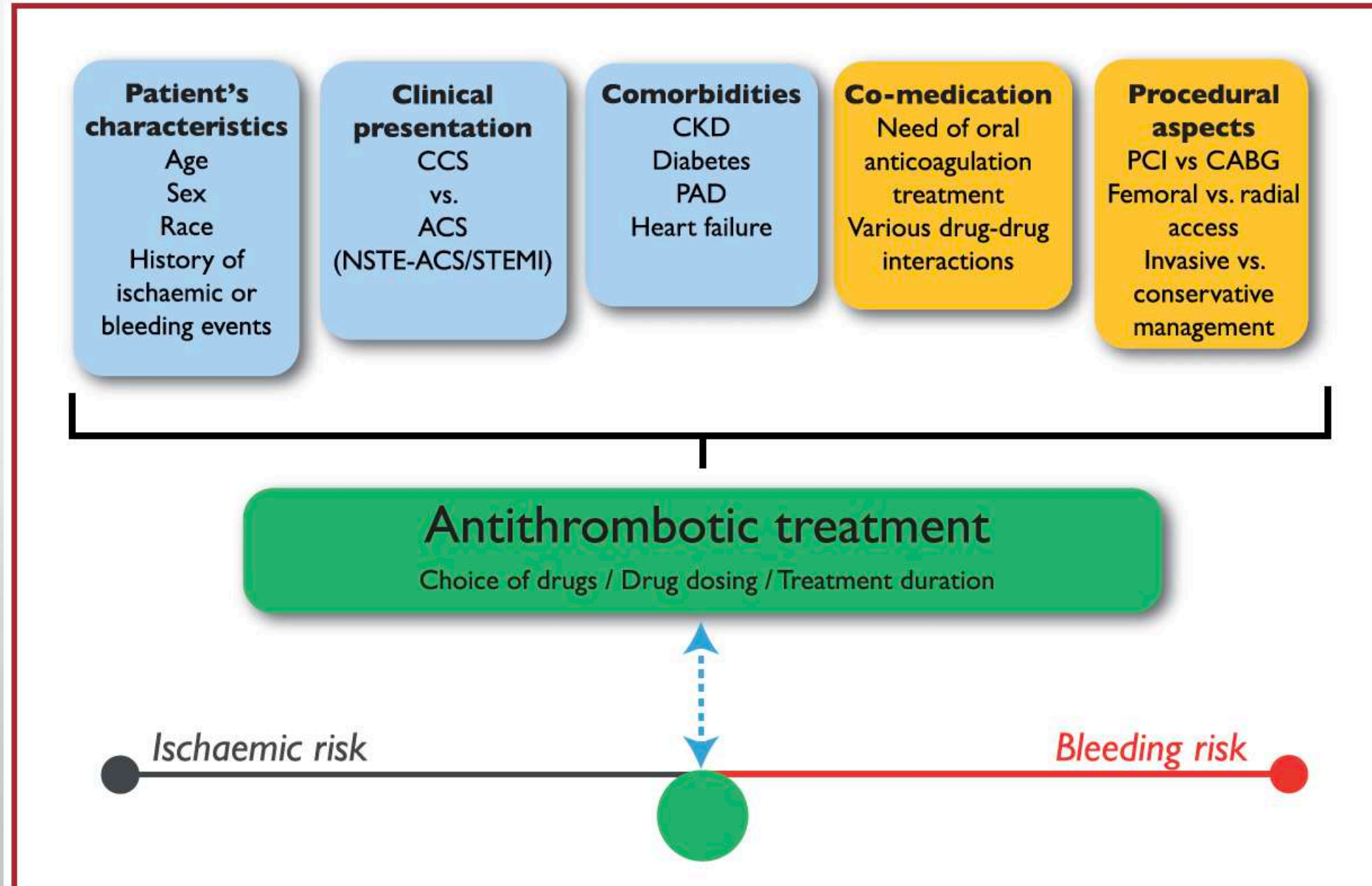
→ À luz da nova evidência clínica e científica, torna-se cada vez mais complexo o equilíbrio entre o **Risco Isquêmico** e **Risco Hemorrágico**;



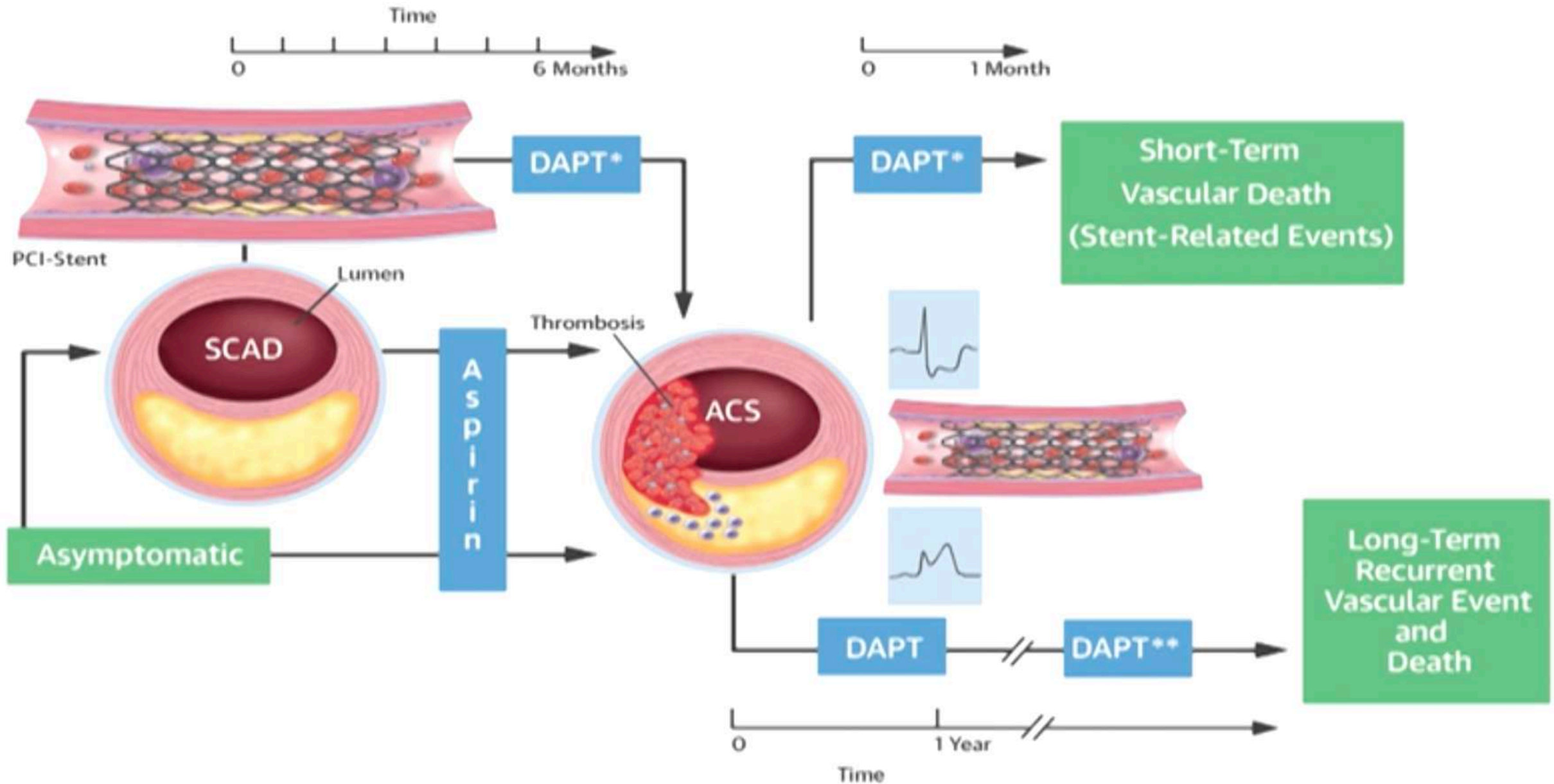
# Terapêutica Antitrombótica



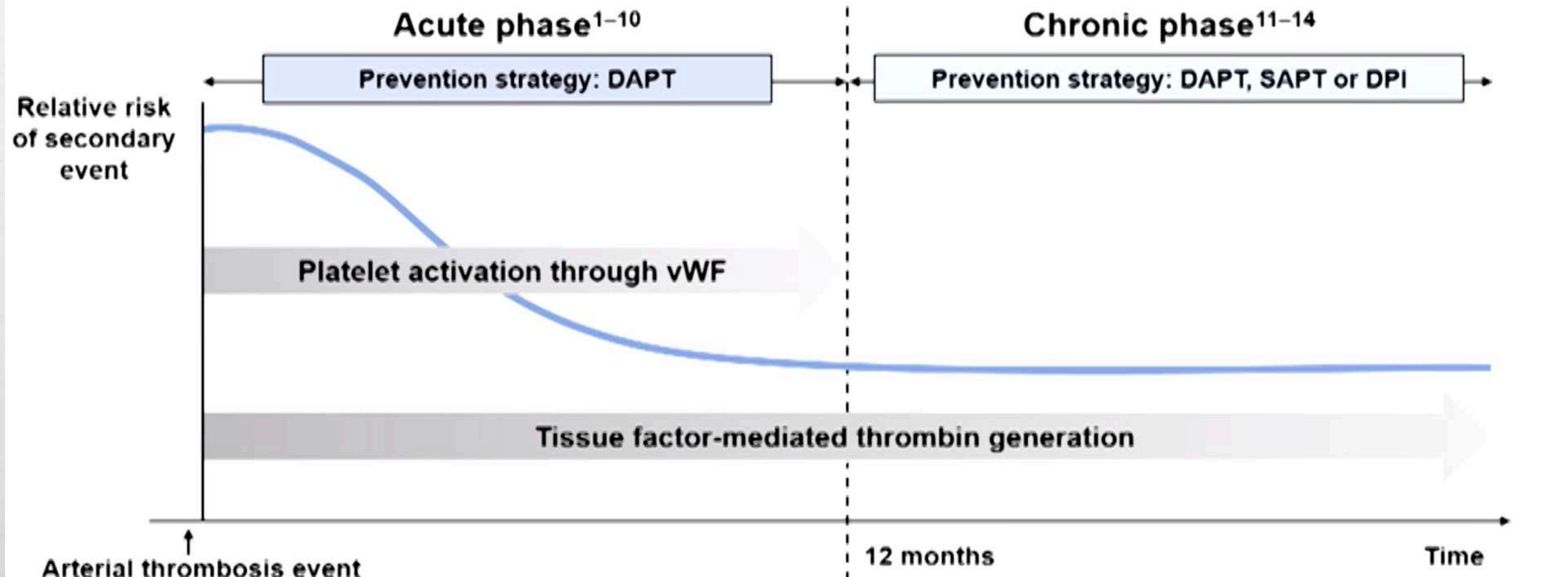
# Determinantes da Terapêutica Antitrombótica



# Dupla Antiagregação Plaquetar (DAPT)

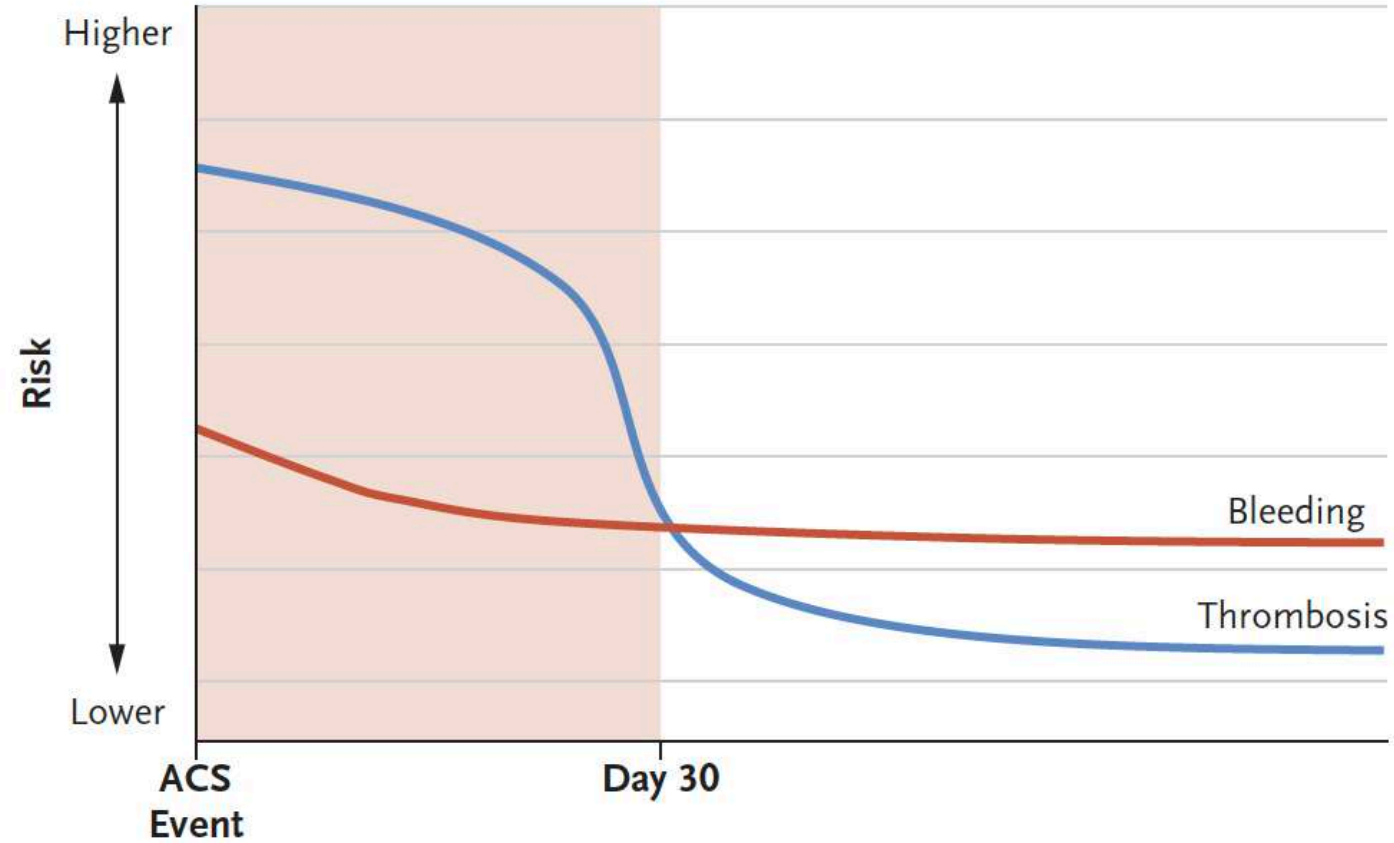


# Tailoring secondary prevention strategies to the underlying pathophysiology following an arterial thrombosis event



- ◆ Plaque rupture causes platelet activation through two distinct pathways, leading to amplification and aggregation<sup>1-2</sup>
- ◆ DAPT is therefore effective in this setting because this is where platelet recruitment, activation and amplification is strongest<sup>3-10</sup>

- ◆ Hypercoagulability persists due to ongoing thrombin generation<sup>11-12</sup>
- ◆ Adding an anticoagulant to aspirin may be effective in this phase<sup>13-14</sup>



**Figure 1.** Risks of Thrombosis and Bleeding after an Acute Coronary Syndrome (ACS).

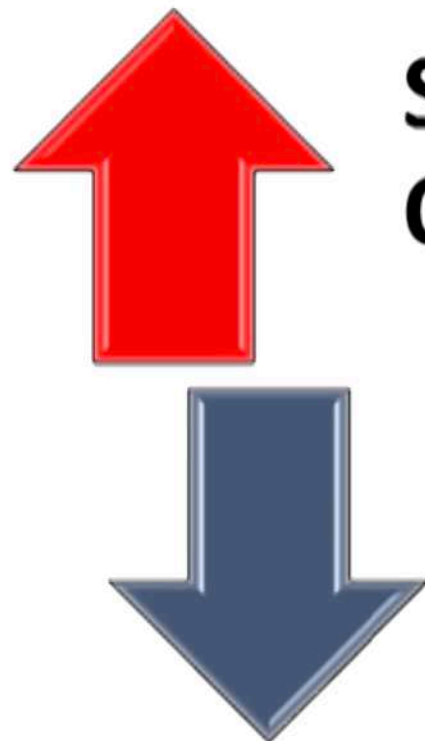
In the first 30 days after an ACS event, the benefits of intensive antithrombotic therapy generally outweigh the increased risk of bleeding. However, this benefit dissipates with additional time after the ACS event, favoring a therapeutic approach that considers the risks of both bleeding and thrombosis.

# Duração da DAPT

Shorter DAPT



Longer DAPT



**Stent  
Oriented**

**Patient  
Centered**

**Efficacy**

*stent  
thrombosis*

*long-term  
recurrent  
events*

**Safety**

**bleeding risk**

**bleeding risk**





**SCA**

**SCC**

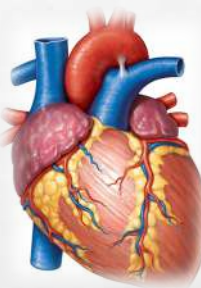
**Populações  
Especiais**



# SCA

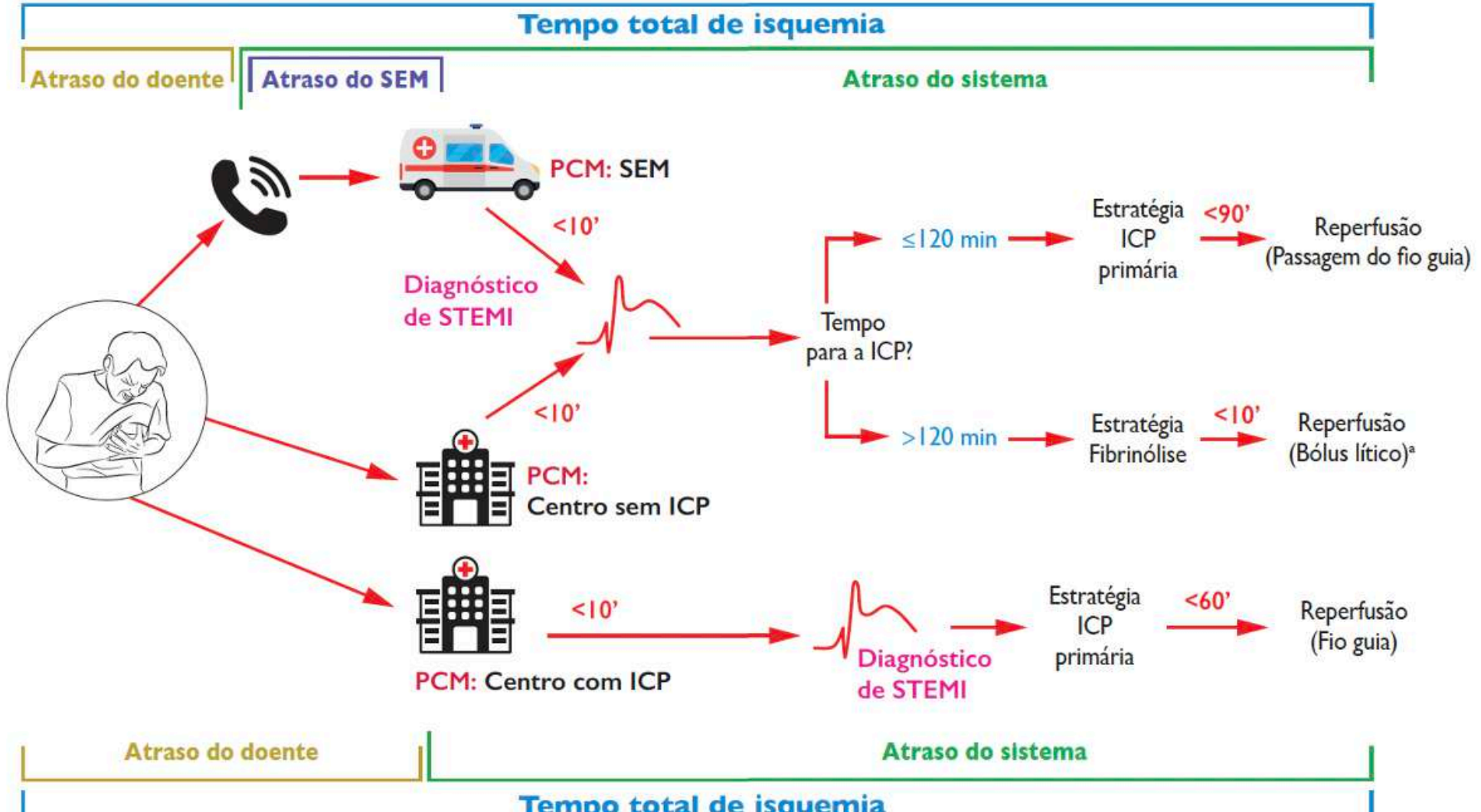
- STEMI
- NSTEMI/AI





## STEMI

**Figura 2** Formas de apresentação do doente, componentes do tempo de isquemia e fluxograma para a seleção da estratégia de reperfusão



# Estratégias de reperfusão da artéria culpável

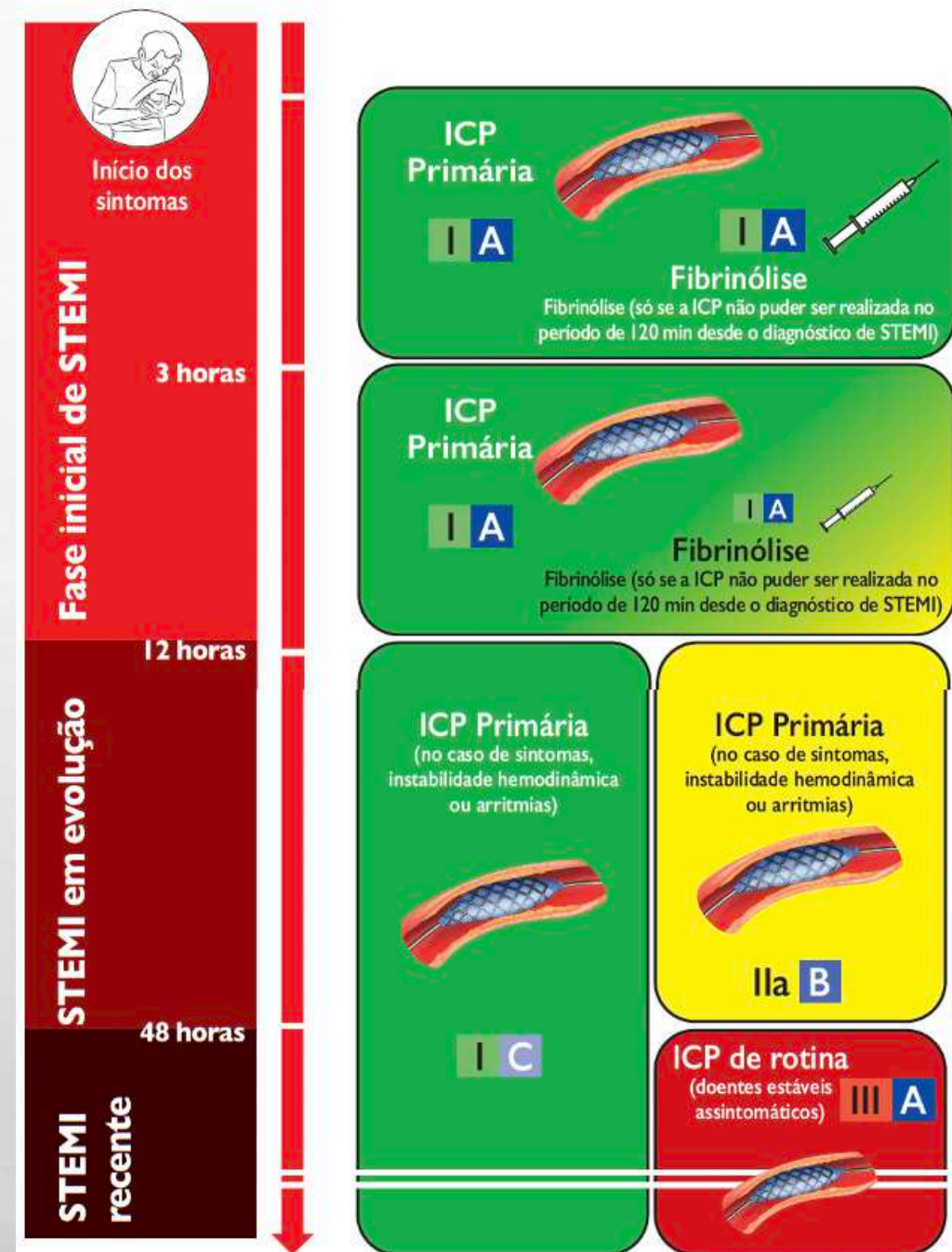
+

## Terap. Antitrombótica

### Objetivos:

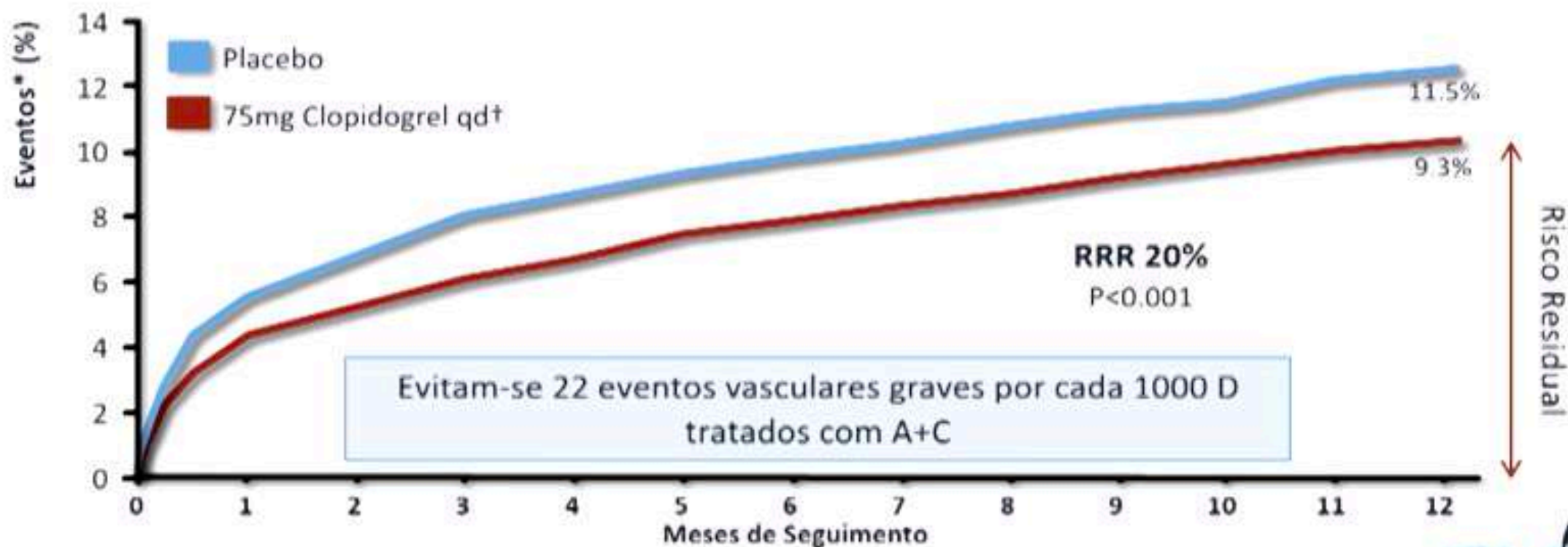
- Inibição plaquetar rápida, potente e previsível
- Anticoagulação parentérica segura e eficaz
- Seleção individualizada:
  - Características clínicas
  - Estratégia de reperfusão
  - Experiência local

Figura 4 Estratégias de reperfusão na artéria relacionada com o enfarte de acordo com o tempo desde o início dos sintomas



# Síndrome Coronária Aguda – “mais é melhor”

## Valor da dupla inibição com AAS e clopidogrel



12562 D com SCA sem elevação ST (primeiras 24 horas).<sup>1</sup> Seguimento 3-12 meses (média 9 meses).

\* Endpoint 1º: morte cardiovascular / EAM não fatal / AVC não fatal.

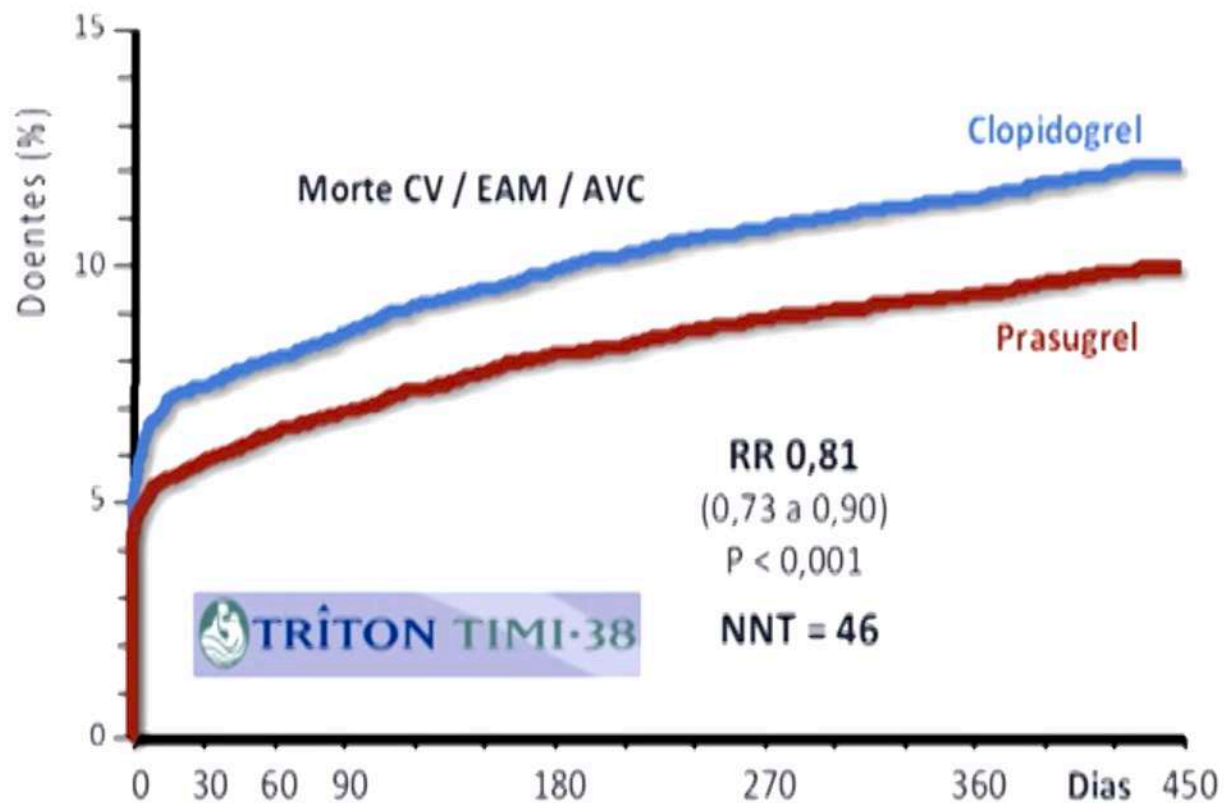
† 300mg dose de carga; AAS 75-325mg id para todos; tratamento mantido até fim do estudo

**Componentes individuais do endpoint 1º:** 7% RRR morte cardiovascular (P=ns); 23% RRR EAM não fatal (P<0,05); 14% RRR AVC (P=ns)

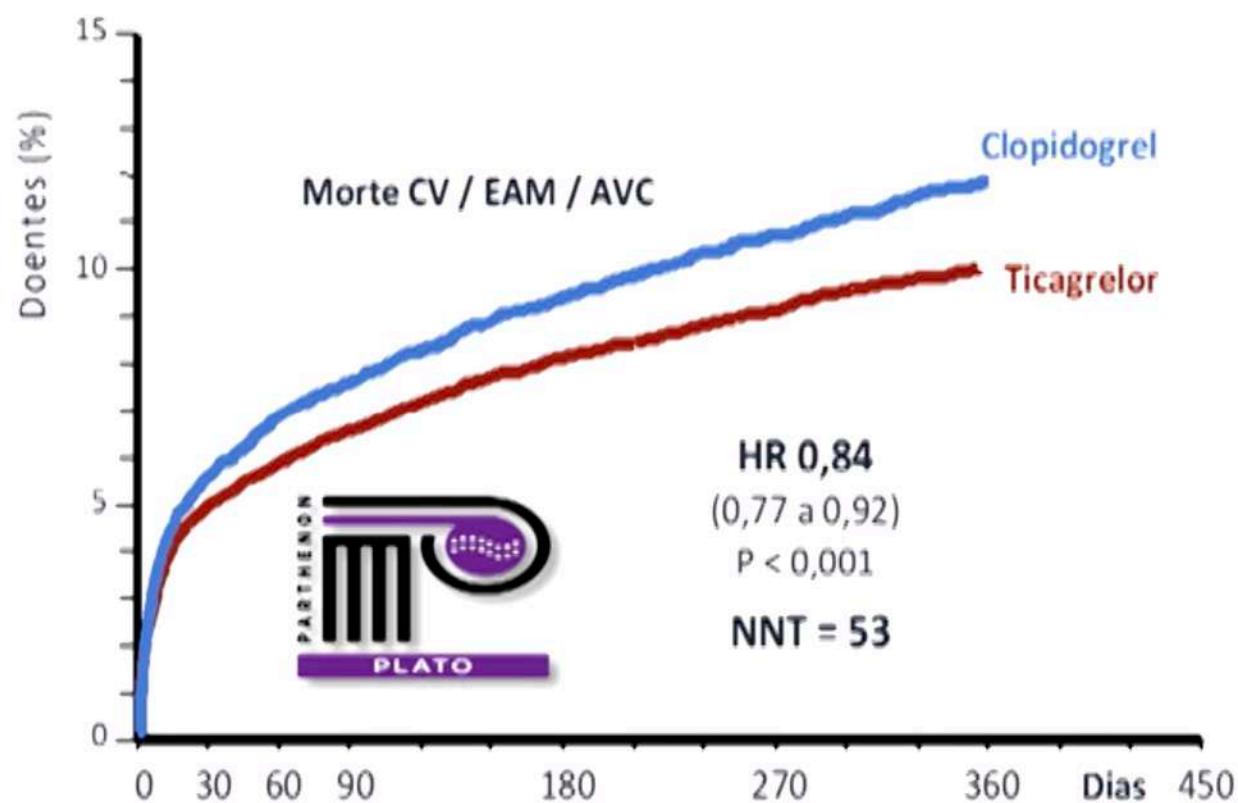
CURE

# Prasugrel e Ticagrelor

## Redução de complicações isquémicas



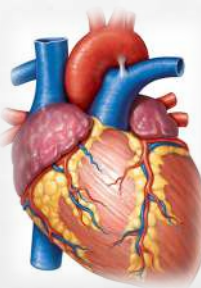
**TRITON TIMI-38:** 13.608 Dts com STEMI ou NSTEMACS de risco moderado/elevado (TIMI  $\geq 3$ ), anatomia coronária conhecida e intenção de ICP, aleatorizados para Pras 60/10 ou Clopi 300/75. Todos os Dts tratados com AAS 75-162 mg od.



**PLATO:** 18.624 Dts com STEMI e intenção de ICP 1ª ou NSTEMACS de risco moderado/elevado, aleatorizados para Tica 180/90 ou Clopi 300-600/75. Todos os Dts tratados com AAS 75-100 mg od.

SCA

SCC

Populações  
Especiais

# STEMI

## Recomendações da European Society of Cardiology



Recomendação	Classe	Evidência
<b>Síndromes Coronárias Agudas</b>		
No STEMI, iniciar um inibidor P2Y <sub>12</sub> potente (prasugrel ou ticagrelor; clopidogrel se estes indisponíveis ou contraindicados) <u>antes (ou o mais tardar na altura) da ICP primária</u>	I	A

**Contraindicações para prasugrel (EMA):** história prévia de AVC ou AIT; prasugrel não está recomendado nos doentes com  $\geq 75$  anos, mas se se quiser usar a dose de manutenção é 5 mg od

**Contraindicações para ticagrelor (EMA):** história de hemorragia intracraniana; inibidores potentes do CYP3A4 (p. ex. cetoconazol, claritromicina, nefazodopa, ritonavir e atazanavir)

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Especiais



# STEMI

Recomendação	Classe	Evidência
<b>Síndromes Coronárias Agudas</b>		
Inibição plaquetária dupla sob a forma de AAS mais ticagrelor ou prasugrel (ou clopidogrel se ticagrelor ou prasugrel indisponíveis ou contraindicados) <u>é recomendada durante 12 meses após ICP, excepto se houver contraindicações como o excessivo risco hemorrágico</u>	I	A

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Especiais**



# STEMI

**EAM com Supra ST**

**Reperusão imediata**

**Antiplaquetários**

**Aspirina 300mg per os  
+  
Prasugrel 60mg per os  
Ticagrelor 180mg per os  
Clopidogrel 600mg per os**

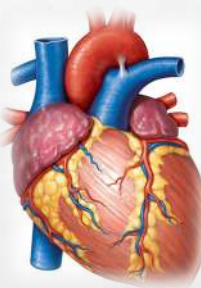
**Anticoagulação**

**HNF 70-100U/kg, máx. 5000U ev  
Enoxaparina 0.5mg/kg ev  
Bivalirudina 0.75mg/kg bolus ev  
seguido de perfusão**

**SCA**

**SCC**

**Populações  
Especiais**



# STEMI

**EAM com Supra ST**

**Reperusão imediata**

**Antiplaquetários**

**Anticoagulação**

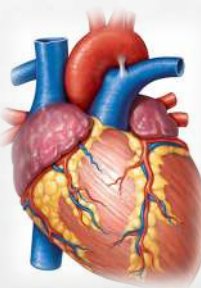
**- 12 MESES -  
Aspirina 75-100mg qd  
+  
Prasugrel 10mg qd per os  
Ticagrelor 90mg bid per os  
Clopidogrel 75mg qd per os**

**Após reperusão:  
  
STOP anticoagulação,  
excepto se outra indicação**

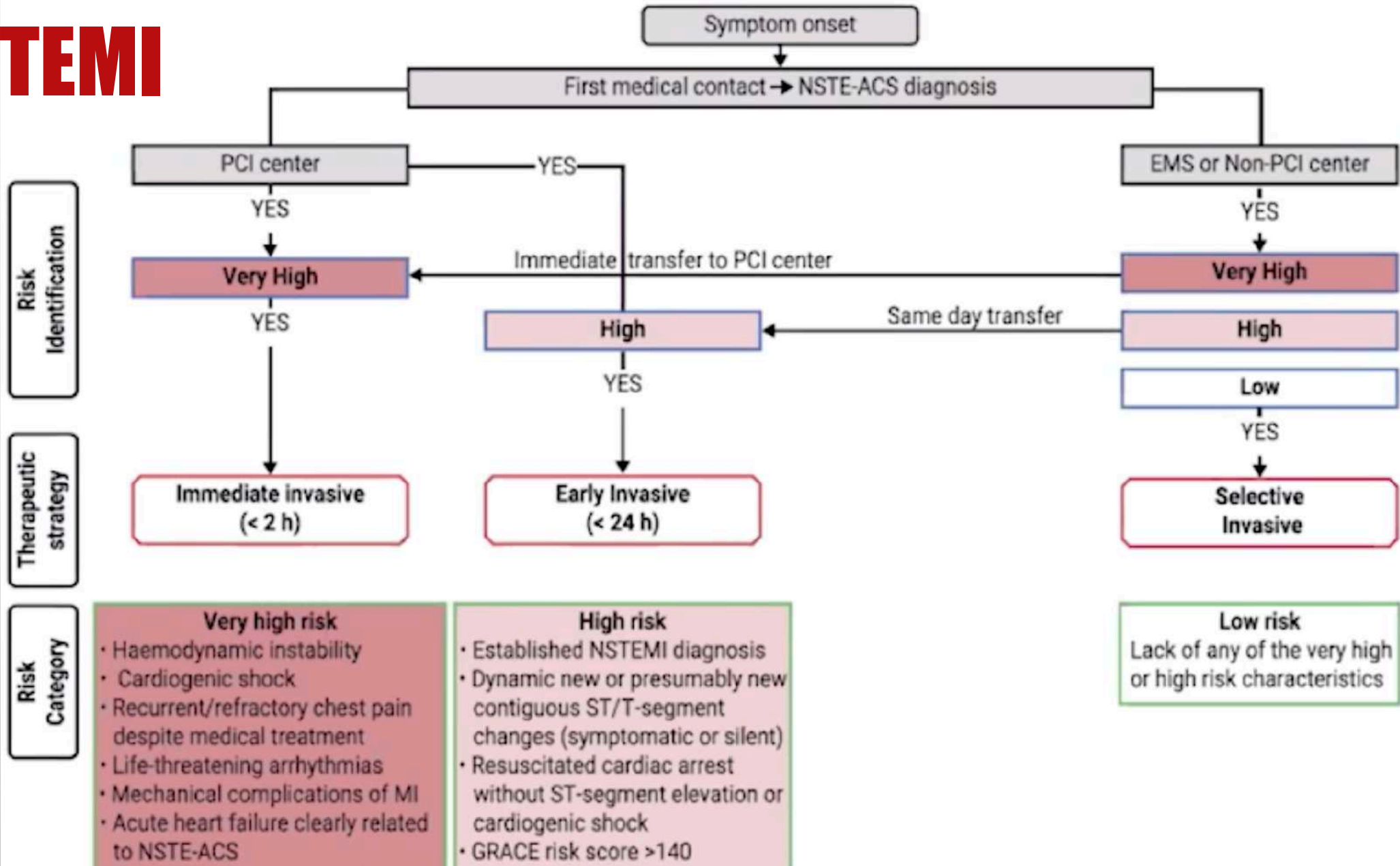
# SCA

# SCC

# Populações Especiais



# NSTEMI



# NSTEMI

## 2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
<b>Antiplatelet treatment</b>		
Aspirin is recommended for all patients without contraindications at an initial oral LD of 150–300 mg (or 75–250 mg i.v.), and at a MD of 75–100 mg o.d. for long-term treatment. <sup>179–181</sup>	I	A
A P2Y <sub>12</sub> receptor inhibitor is recommended in addition to aspirin, and maintained over 12 months unless there are contraindications or an excessive risk of bleeding. <sup>170,171,182</sup>	I	A
Options are:		
• Prasugrel in P2Y <sub>12</sub> receptor inhibitor-naïve patients proceeding to PCI (60 mg LD, 10 mg/d as standard dose, 5 mg/d for patients aged ≥75 years or with a body weight <60 kg). <sup>171</sup>	I	B
• Ticagrelor irrespective of the planned treatment strategy (invasive or conservative) (180 mg LD, 90 mg b.i.d.). <sup>170</sup>	I	B
• Clopidogrel (300–600 mg LD, 75 mg daily dose), only when prasugrel or ticagrelor are not available, cannot be tolerated, or are contraindicated. <sup>182,183</sup>	I	C
Prasugrel should be considered in preference to ticagrelor for NSTEMI-ACS patients who proceed to PCI. <sup>174</sup> ← ISAR-REACT	IIa	B

# Recommendations for antithrombotic treatment in non-ST-segment elevation acute coronary syndrome patients undergoing percutaneous coronary intervention (3)

Recommendations

Class

Level

Antiplatelet treatment (continued)

## *Estratégia não invasiva*

Pre-treatment with a P2Y<sub>12</sub> receptor inhibitor may be considered in patients with NSTEMI-ACS who are not planned to undergo an early invasive strategy and do not have an HBR.

IIb

C

## *Estratégia invasiva*

It is not recommended to administer routine pre-treatment with a P2Y<sub>12</sub> receptor inhibitor in patients in whom coronary anatomy is not known and an early invasive management is planned.

III

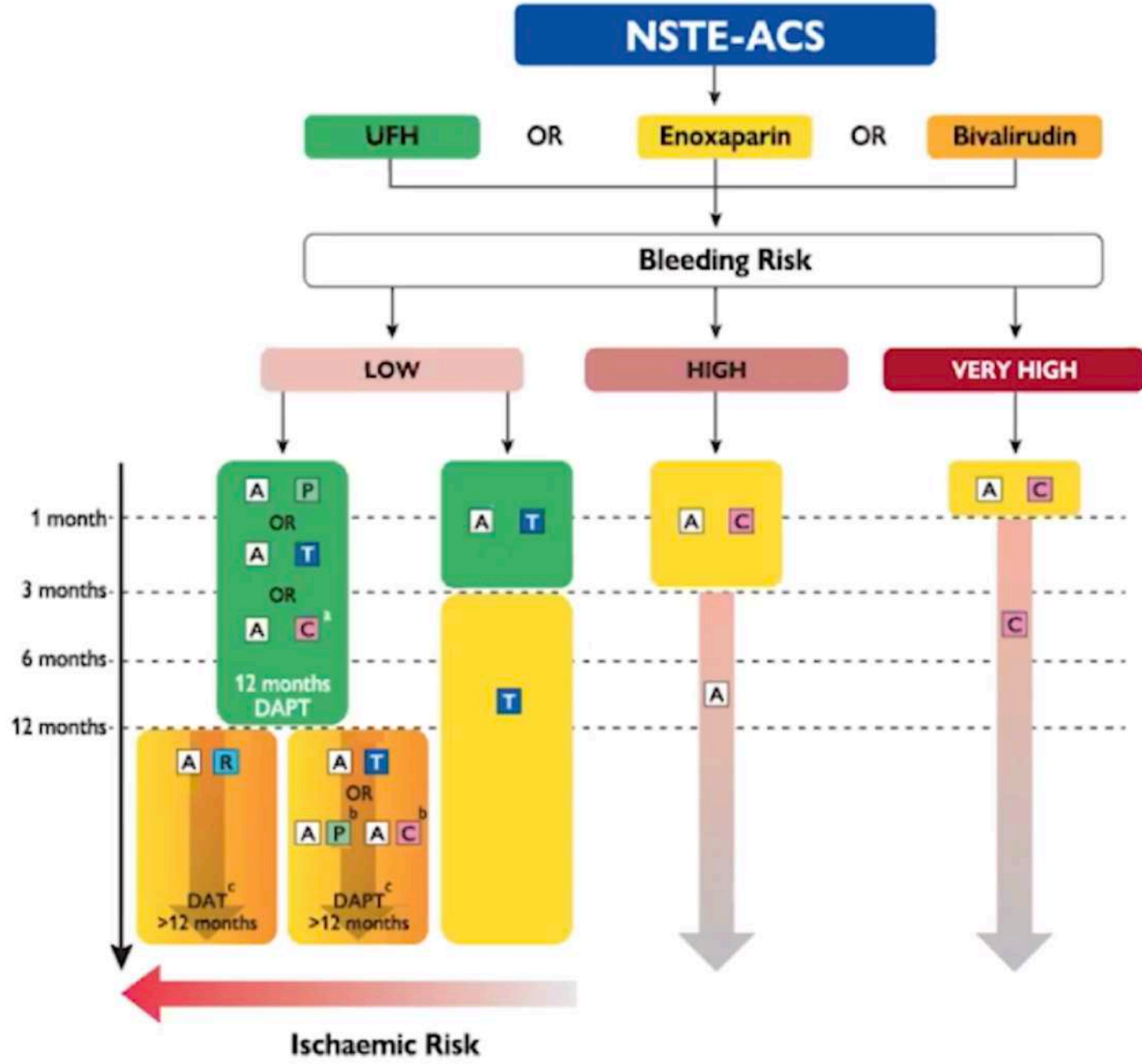
A

Anticoagulation for PCI

Treatment duration

Antithrombotic drugs

- A = Aspirin
- C = Clopidogrel
- P = Prasugrel
- R = Rivaroxaban
- T = Ticagrelor



2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

**Very High**

Hemorragia < 1M  
 Cirurgia não adiável

**High**

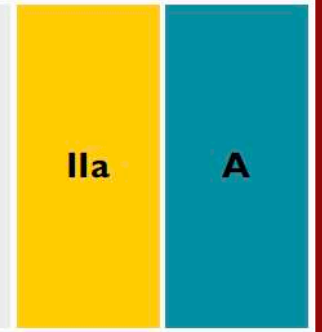
PRECISE-DAPT > 25  
 Critérios ARC-HBR

## 2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

### Prolonging antithrombotic treatment duration

Adding a second antithrombotic agent to aspirin for extended long-term secondary prevention should be considered in patients with a high risk of ischaemic events and without increased risk of major or life-threatening bleeding (see *Tables 9 and 11* for options).<sup>162,212,213,214,223</sup>

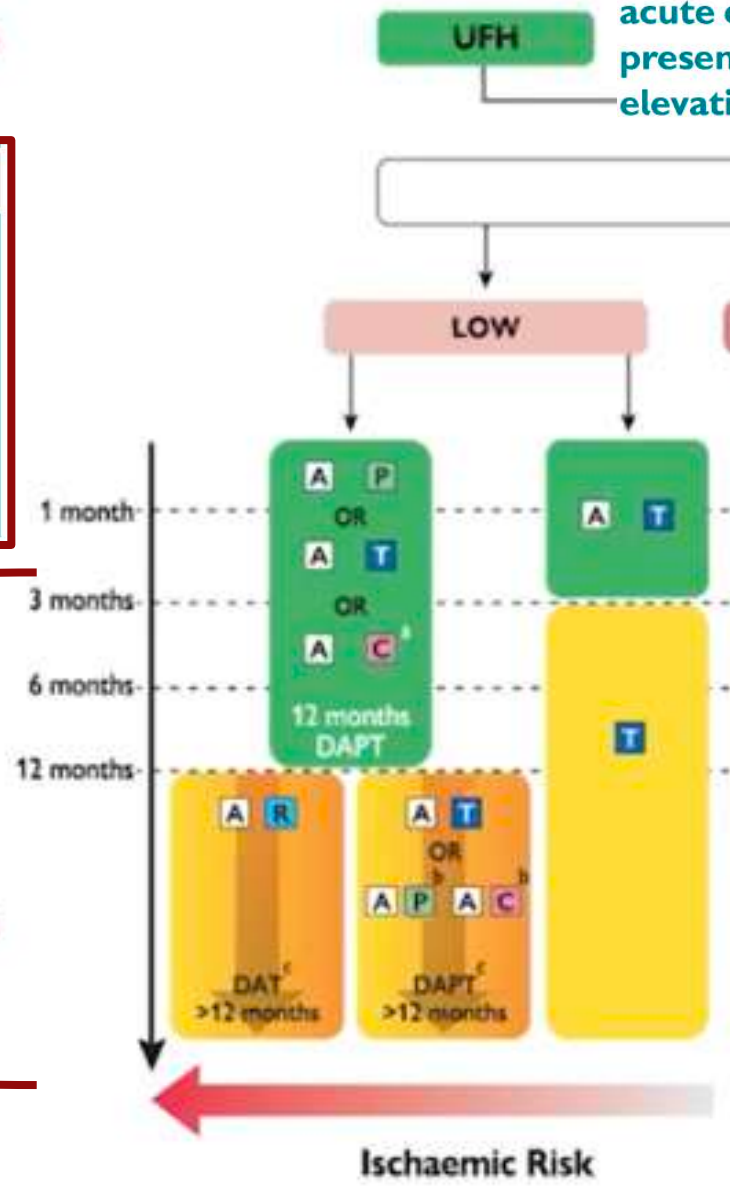
Anticoagulation for PCI



Treatment duration

Antithrombotic drugs

- A** = Aspirin
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The NEW ENGLAND JOURNAL of MEDICINE  
 ESTABLISHED IN 1812 OCTOBER 5, 2017 VOL. 377 NO. 14

Rivaroxaban with or without Aspirin in Stable Cardiovascular Disease



ORIGINAL ARTICLE

Ticagrelor with or without Aspirin in High-Risk Patients after PCI





**SCA**

**SCC**

**Populações  
Especiais**

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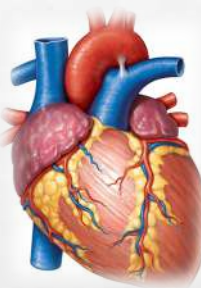
SCC



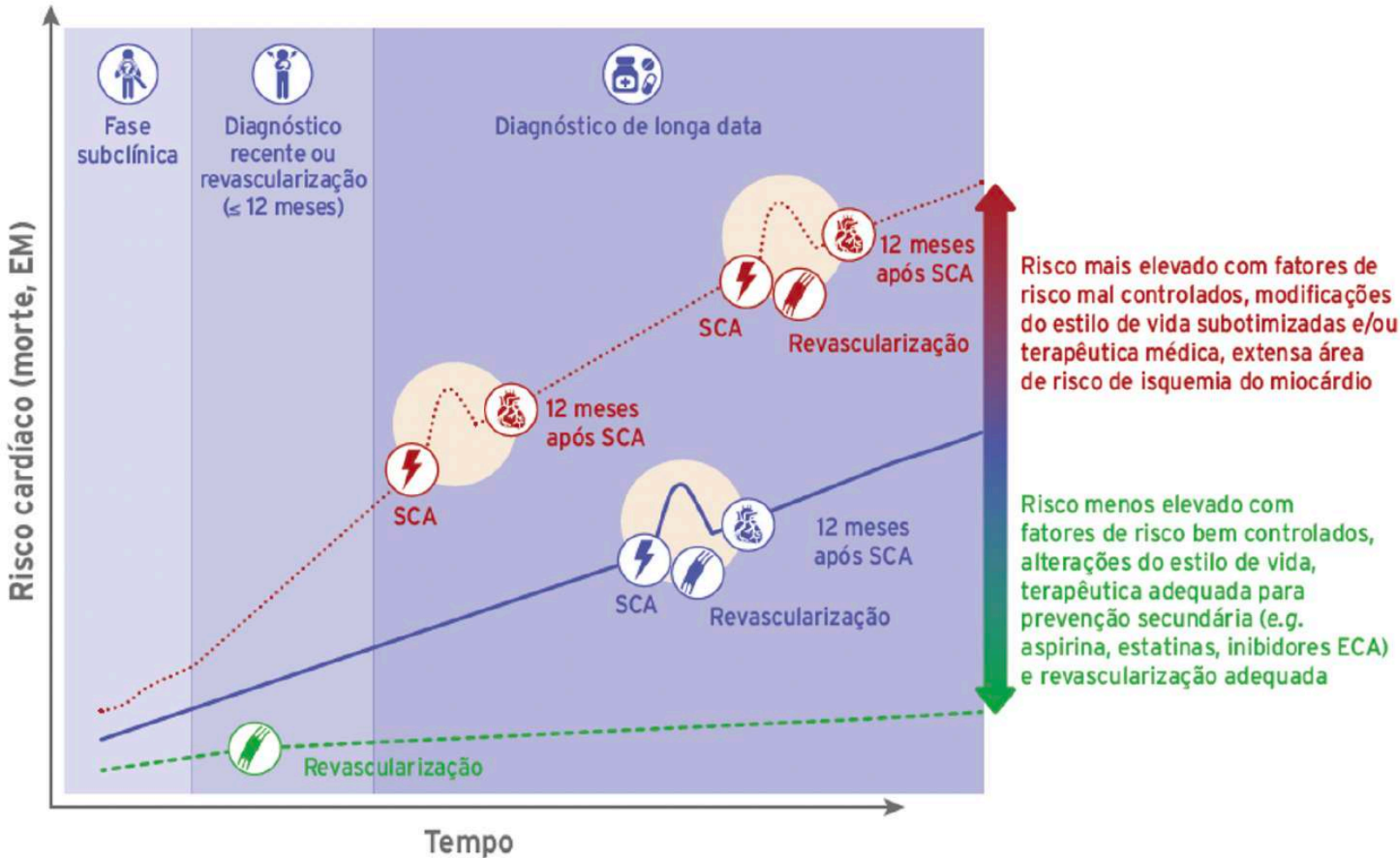
# SCA

# SCC

# Populações Especiais



## Doença Coronária “Estável” → Síndrome Coronário Crônico



**RISCO VARIÁVEL DE EVENTOS**  
1-3%/ano a >7-10%/ano

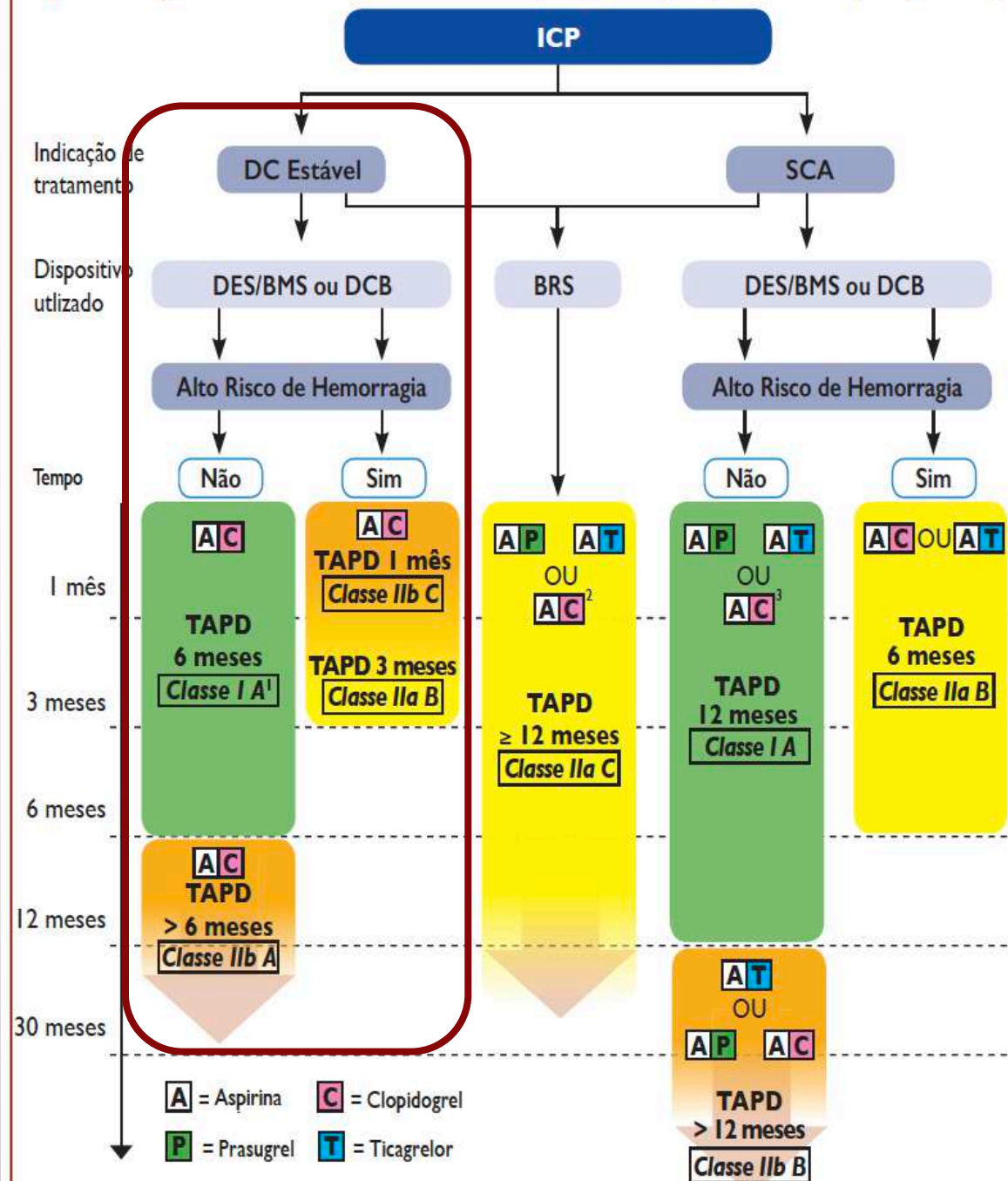
Nas Recomendações atuais cada capítulo trata dos principais cenários clínicos das Síndromes Coronárias Crônicas. Esta estrutura visa simplificar a utilização destas Recomendações na prática clínica.  
ECA = enzima de conversão da angiotensina; EM = enfarte do miocárdio; SCA = síndromes coronárias agudas.

# SCC

## Antiagregação após ICP

- 6 meses (A + C)
- Se risco hemorrágico elevado podemos encurtar para 3 meses

Figura 3 Algoritmo da terapêutica antiagregante plaquetária dupla (TAPD)





# Adding a second antithrombotic drug to aspirin for long-term secondary prevention

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

Adding a second antithrombotic drug to aspirin for long-term secondary prevention should be considered in patients with a **high risk** of ischaemic events<sup>c</sup> and without high bleeding risk<sup>d</sup> (see *Table 9* for options).<sup>289,296,297,307</sup>

Adding a second antithrombotic drug to aspirin for long-term secondary prevention may be considered in patients with at least a **moderately increased risk** of ischaemic events<sup>e</sup> and without high bleeding risk<sup>d</sup> (see *Table 9* for options).<sup>289,296,297,307</sup>

IIa	A
IIb	A

## Drug option

## Dose

## Indication

## Additional cautions

Clopidogrel

75 mg o.d.

Post-MI in patients who have tolerated DAPT for 1 year

Prasugrel

10 mg o.d or 5 mg o.d.; if body weight <60 kg or age >75 years

Post-PCI for MI in patients who have tolerated DAPT for 1 year

Age >75 years

Rivaroxaban

2.5 mg b.i.d.

Post-MI >1 year or multivessel CAD

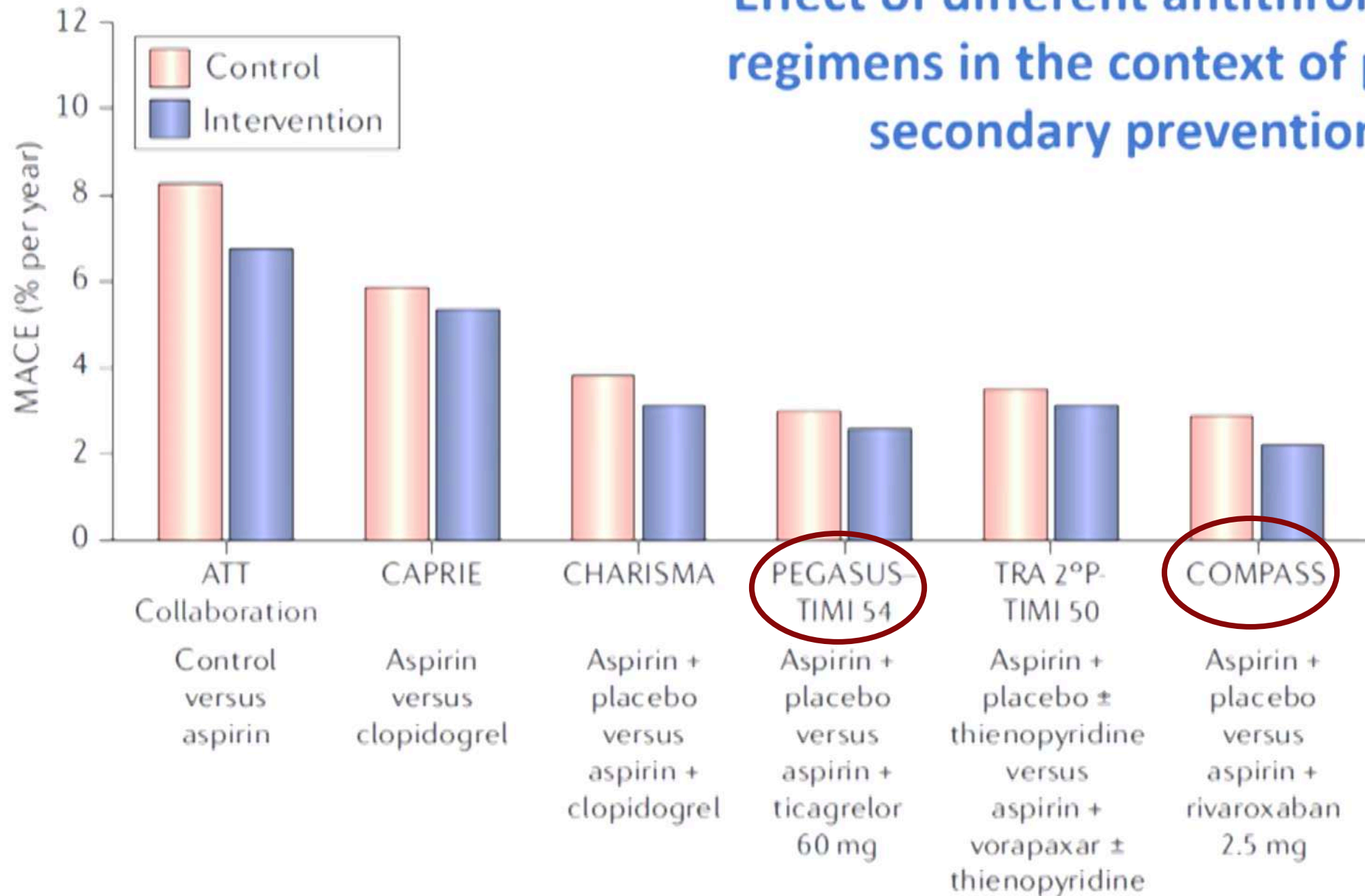
Creatinine clearance  
15-29 mL/min

Ticagrelor

60 mg b.i.d.

Post-MI in patients who have tolerated DAPT for 1 year

## Effect of different antithrombotic regimens in the context of proven secondary prevention



## Multivessel CAD + one of the following:

- DM
- recurrent MI
- PAD
- or CKD (eGFR 15 -59 mL/min)



## Antithrombotic therapy in patients with AF and in sinus rhythm

Adding a **second antithrombotic drug** to aspirin for long-term secondary prevention should be considered in patients with high risk of ischaemic events<sup>a</sup> and without high bleeding risk.<sup>b</sup>

Adding a second antithrombotic drug to aspirin for long-term secondary prevention may be considered in patients with at least a moderately increased risk of ischaemic events<sup>c</sup> and without high bleeding risk.<sup>b</sup>

IIa

A

IIb

A

- History of intracerebral haemorrhage or ischaemic stroke,
- Recent GI bleeding or anaemia due to GI blood loss, other GI pathology associated with increased bleeding risk,
- liver failure,
- bleeding diathesis or coagulopathy,
- extreme old age or frailty,
- renal failure requiring dialysis or with eGFR <15 mL/min/1.73 m<sup>2</sup>



European Heart Journal (2019) 40, 1–11  
doi:10.1093/eurheartj/ehz015

ESC GUIDELINES



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

## in sinus rhythm

Adding a second antithrombotic drug to aspirin for long-term secondary prevention should be considered in patients with high risk of ischaemic events<sup>a</sup> and without high bleeding risk.<sup>b</sup>

IIa

A

Adding a second antithrombotic drug to aspirin for long-term secondary prevention may be considered in patients with at least a moderately increased risk of ischaemic events<sup>c</sup> and without high bleeding risk.<sup>b</sup>

IIb

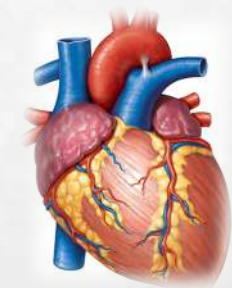
A



**SCA**

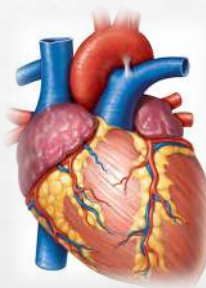
**SCC**

**Populações  
Especiais**



# Populações Especiais



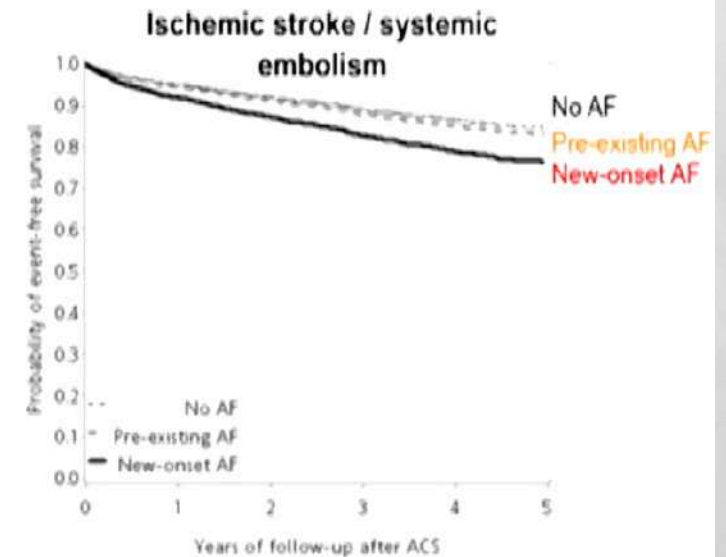
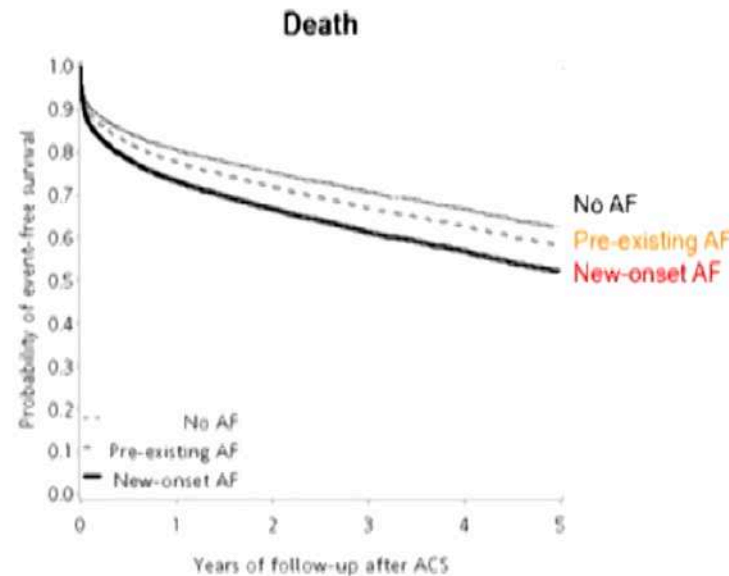
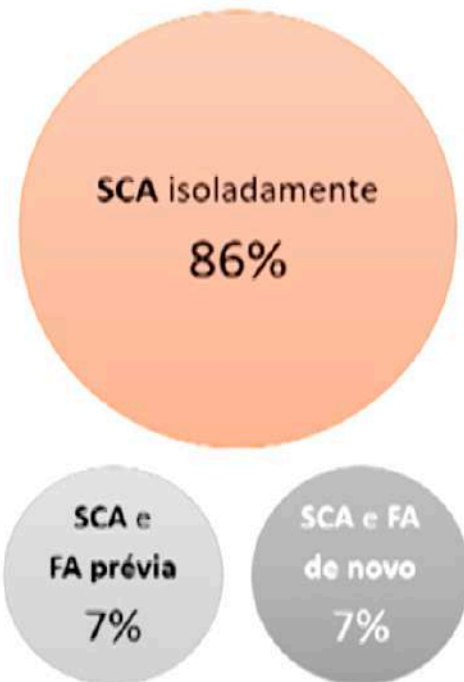


# FA e Doença Coronária

Associação entre **FA** e **Doença Coronária** é muito frequente: aproximadamente **1 em cada 5** doentes com FA será submetido a angioplastia coronária ou terá uma síndrome coronária aguda<sup>1</sup>



Retrospective cohort study - Taiwan's National Health Insurance Research Database; 6663 patients with ACS<sup>2</sup>



Doentes com FA e SCA têm pior prognóstico

1. Mehta SR. *N Engl J Med* 2019;380(16):1580-1581.

2. Wang CL. *Cardiol Ther.* 2019; 117-127.

SCA

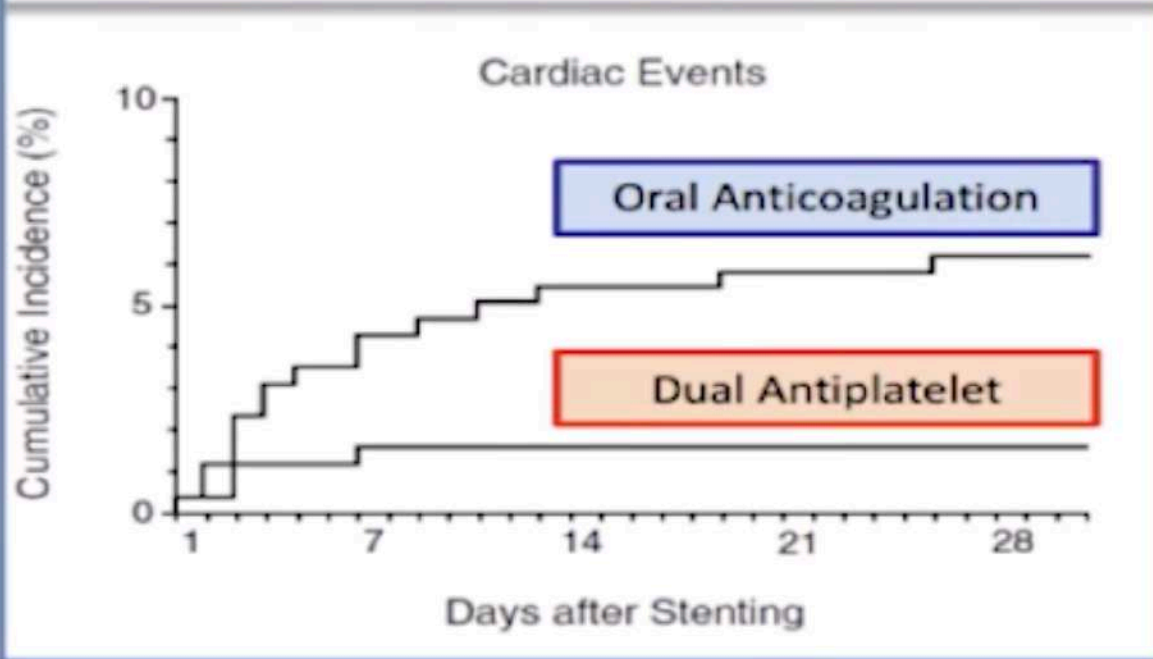
SCC

Populações Especiais



# FA e Doença Coronária

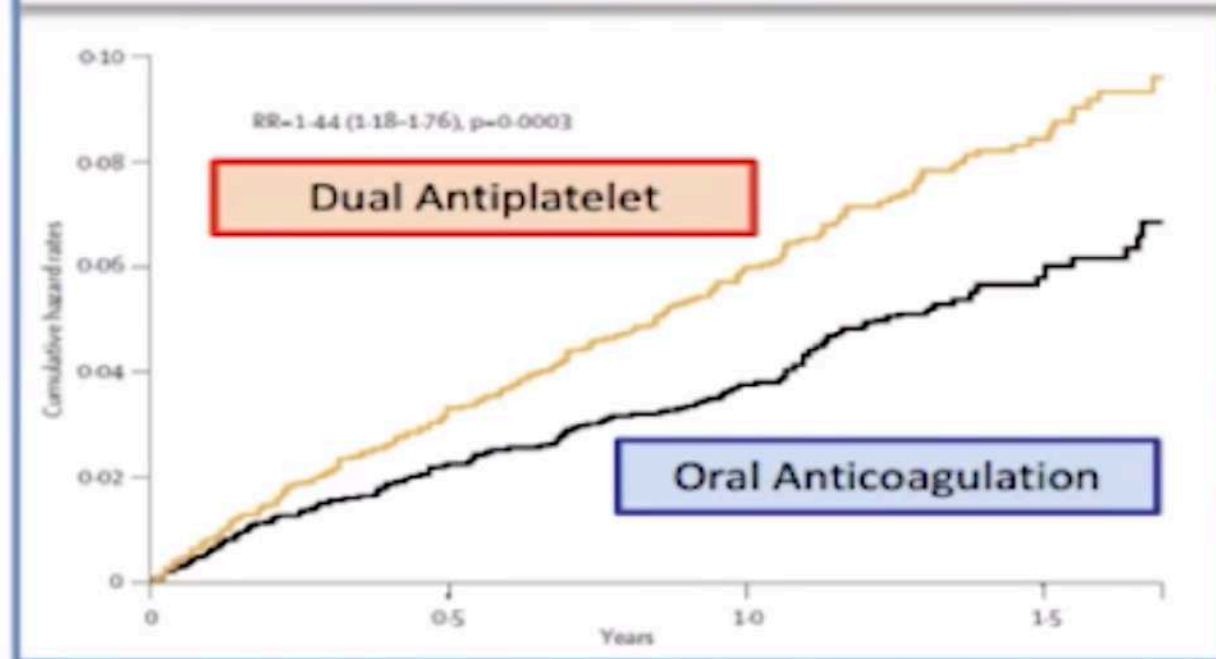
## Coronary stent implantation



ISAR, NEJM 1996

+

## Atrial fibrillation



ACTIVE-W Lancet 2006

=

Dual Antiplatelet

+

Oral Anticoagulation

**Triple Antithrombotic Therapy**

SCA

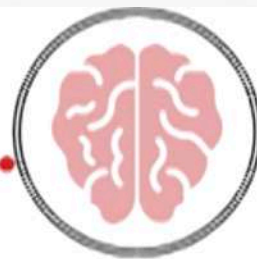
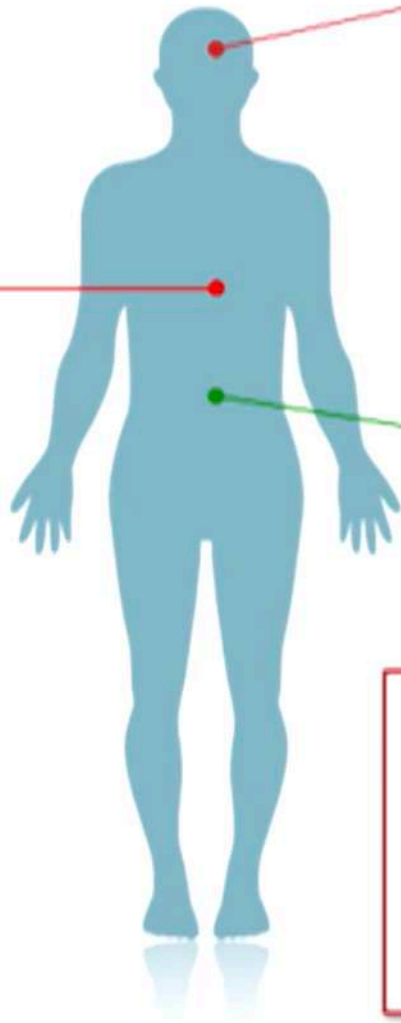
SCC

Populações  
Especiais



# FA e Doença Coronária

Prevenção de  
**Eventos Trombóticos**  
(SCA / trombose stent)



Prevenção de  
**Eventos Embólicos**  
(AVC / embolismo sistêmico)



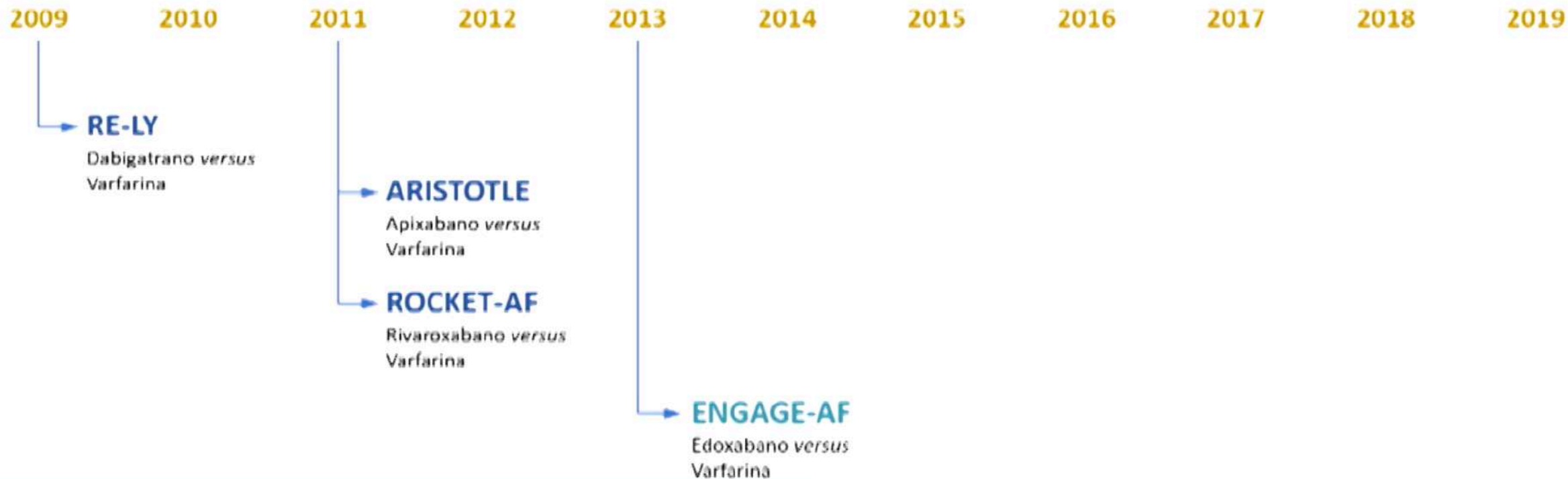
Minimização do risco  
**hemorrágico** inerente à  
anticoagulação / antiagregação

- ACO com NOAC ou com varfarina?
- NOAC em dose total ou reduzida?
- Antiagregação em monoterapia? Clopidogrel ou AAS?
- Antiagregação dupla? Durante quanto tempo?

SCA

SCC

Populações  
Especiais

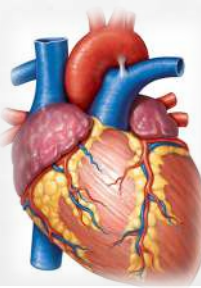


**Doentes com FA:**

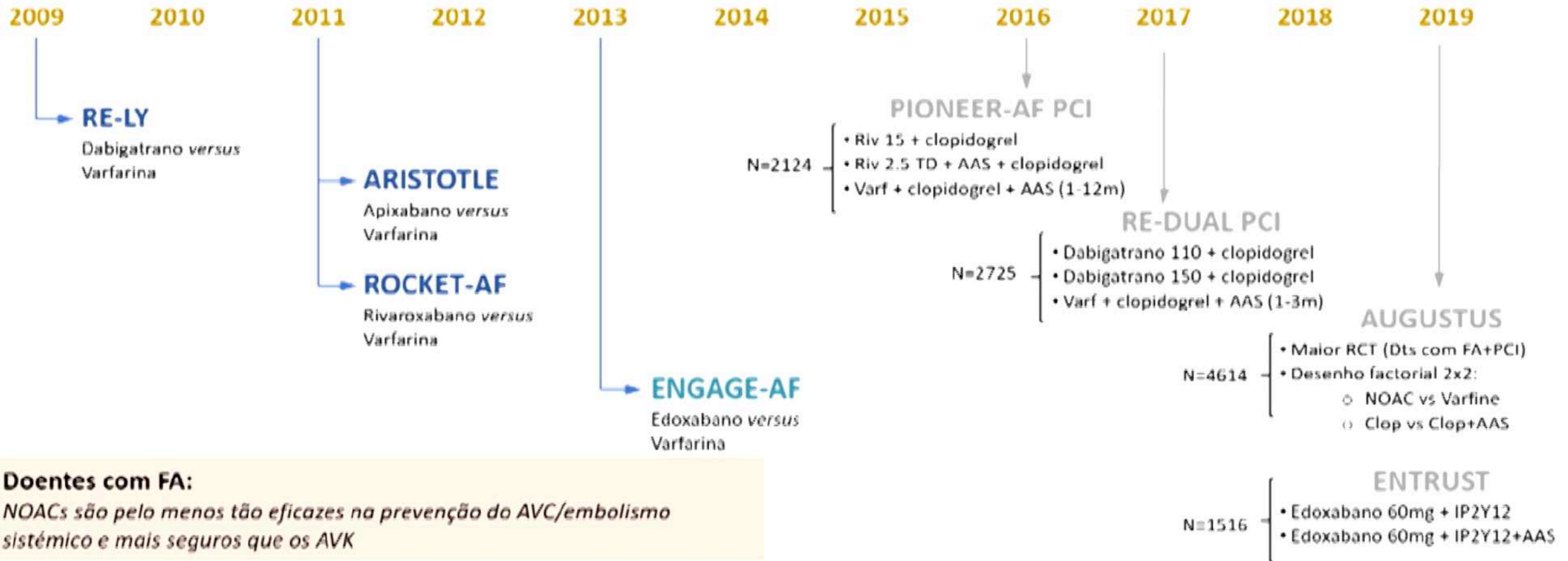
*NOACs são pelo menos tão eficazes na prevenção do AVC/embolismo sistémico e mais seguros que os AVK*

SCA

SCC

Populações  
Especiais

# FA e Doença Coronária



## Doentes com FA:

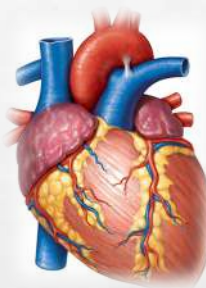
NOACs são pelo menos tão eficazes na prevenção do AVC/embolismo sistémico e mais seguros que os AVK

## Doentes com FA submetidos a ICP:

Terapêutica dupla com NOAC e clopidogrel tem menor risco hemorrágico, sem sinais de alarme quanto ao risco isquémico

SCA

SCC

Populações  
Especiais

# FA e Doença Coronária



Os estudos **RE-DUAL PCI**, **PIONEER AF-PCI**, **AUGUSTUS** e **ENTRUST-PCI** avaliaram o uso de NOAC+IP2Y12 em doentes com FA submetidos a PCI **são diferentes e complementares na informação** que nos trazem, pois têm desenhos e definições diferentes.

Na grande maioria dos doentes uma combinação simples de **NOAC + clopidogrel** será a **melhor opção terapêutica**, após alta do doente, tendo em conta os estudos *mais recentes*

# AF patients undergoing PCI for NSTEMI-ACS

Time from treatment initiation



Default Strategy

High Bleeding Risk

High Ischaemic Risk

up to 1 week (in hospital)

Triple therapy: (N)OAC + DAPT (aspirin + P2Y<sub>12</sub> receptor inhibitor)

1 month

Double Therapy (N)OAC + SAPT

Triple Therapy

3 months

Double Therapy (N)OAC + SAPT

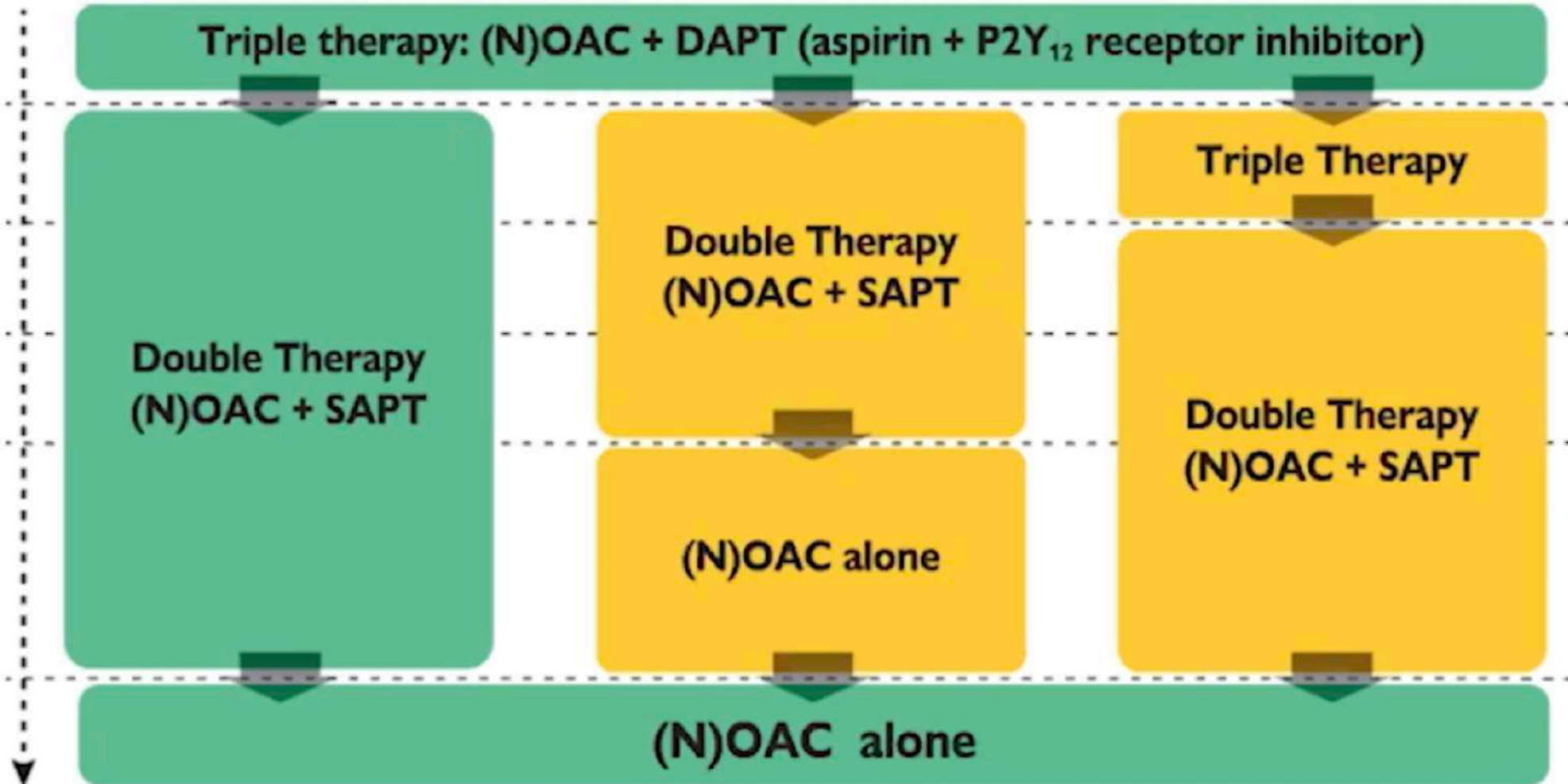
Double Therapy (N)OAC + SAPT

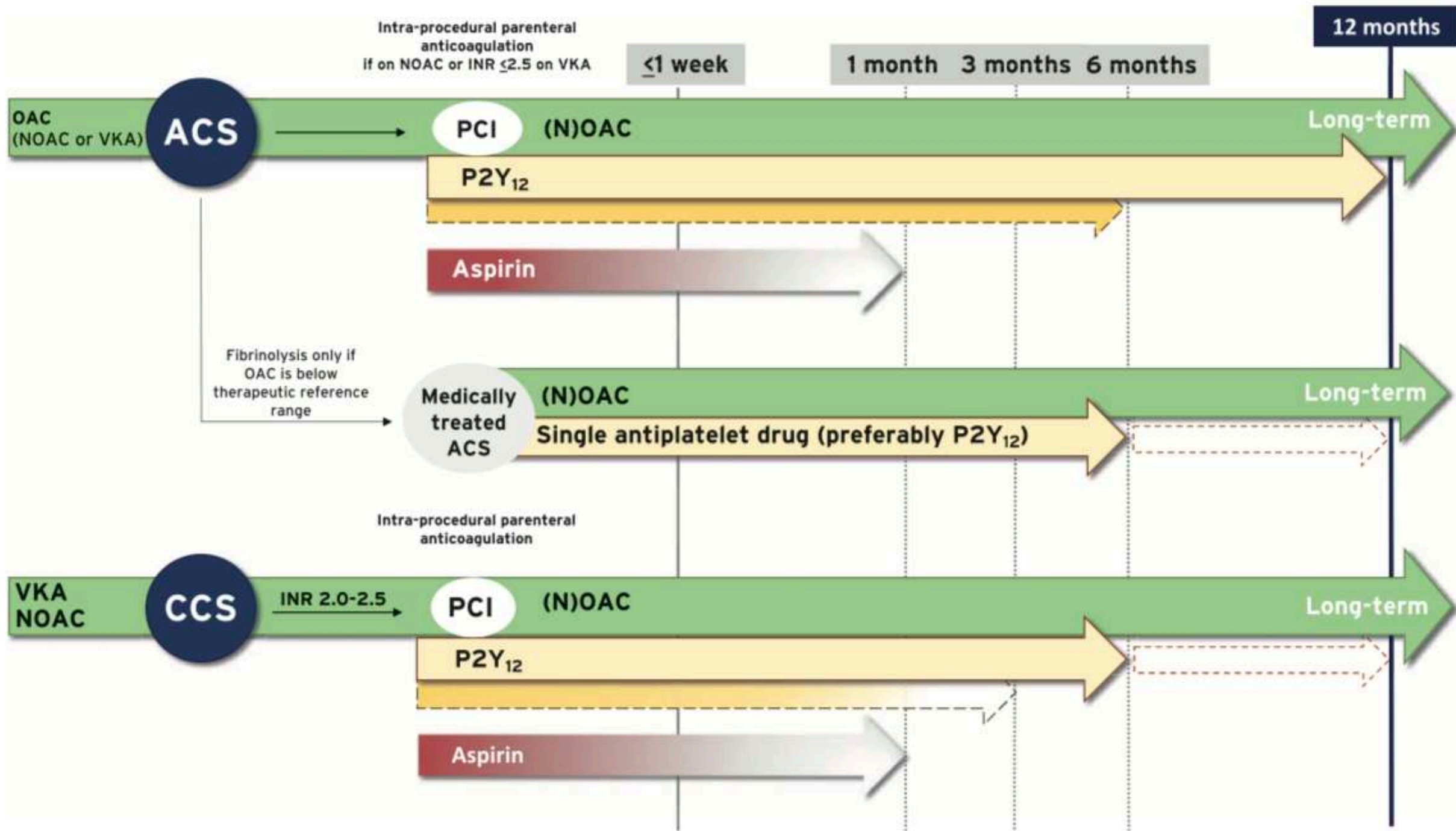
6 months

(N)OAC alone

12 months

(N)OAC alone





# From meta-analysis to the individual patient with atrial fibrillation and coronary artery disease: the complexity of antithrombotic treatment in real-world clinical practice and the need for a tailored approach



**PATIENT FACTORS**

- Prior MI or stent thrombosis
- Peripheral artery disease
- Recurrent ischemic events on DAPT
- Clinical presentation (ACS)
- Prior ischemic stroke
- Current smoker
- Heart failure
- Diabetes
- Chronic Kidney Disease or ESRD



**ANGIOGRAPHIC FACTORS**

- Multi-vessel disease
- In-stent restenosis
- Multiple ( $\geq 3$ ) stents
- Long ( $>60\text{mm}$ ) or small ( $<3\text{mm}$ ) stents
- Left main or proximal LAD stenting
- Treatment of a chronic total occlusion
- Stenting of a bifurcation lesion
- Bioabsorbable vascular scaffold
- First generation DES

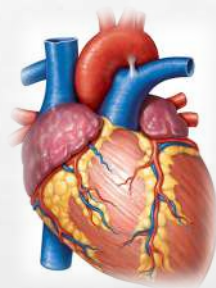
- Prior bleeding/recent bleeding
- Very elderly/frail patient
- Naïve to oral anticoagulation
- Low body weight ( $< 50\text{Kg}$ )
- Anemia or thrombocytopenia
- Active malignancy
- Chronic Kidney Disease or ESRD
- Liver disease
- Uncontrolled hypertension
- Prior stroke or intracranial bleed
- Excess alcohol consumption
- Concomitant NSAID



**PATIENT FACTORS**

**ISCHEMIC RISK**

**BLEEDING RISK**



**Table 1. Calculation of the DAPT Score.\***

Variable	Points
Age (yr)	
≥75	-2
65-74	-1
≤64	0
Diabetes mellitus	1
Current cigarette smoker	1
Prior MI or PCI	1
MI at presentation	1
CHF or left ventricular ejection fraction <30%	2
Stent diameter <3 mm	1
PCI of vein graft	2
Paclitaxel-eluting stent	1

\* The score for dual antiplatelet therapy (DAPT) ranges from -2 to 10. A score of 2 or higher suggests that the magnitude of the benefit from a reduction in ischemic events is greater than the risk of bleeding with DAPT continued for more than 12 months. CHF denotes congestive heart failure, MI myocardial infarction, and PCI percutaneous coronary intervention.

**HBR is defined as a BARC 3 or 5 bleeding risk of ≥4% at 1 year or a risk of an intracranial hemorrhage (ICH) of ≥ 1% at 1 year (1 major or 2 minor)**

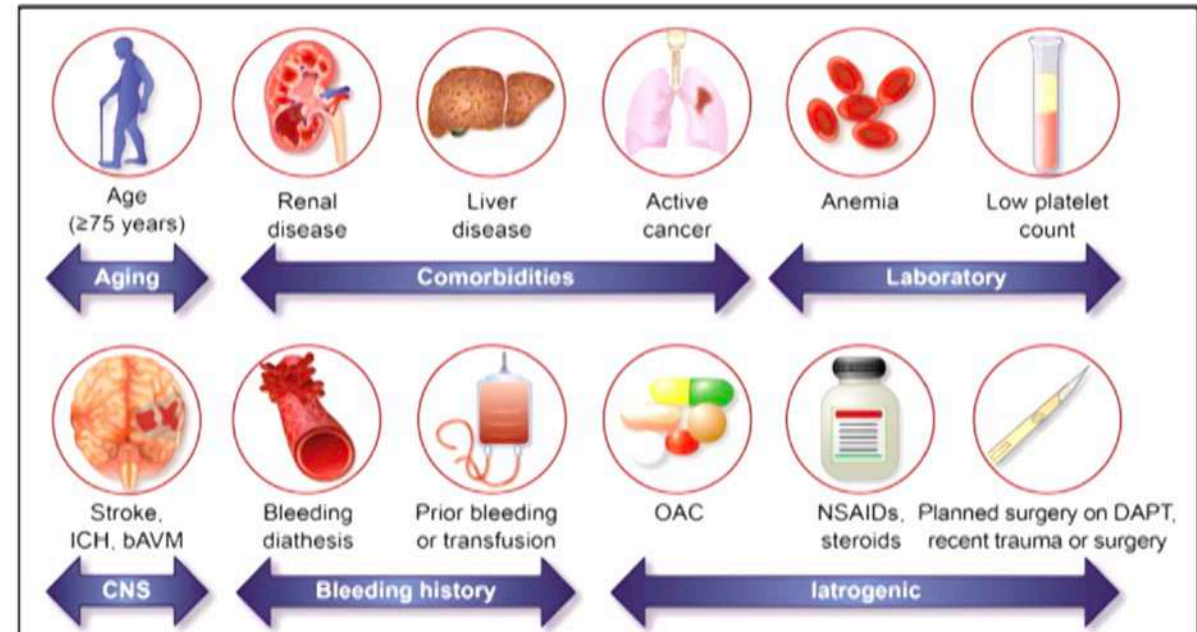
WHITE PAPER

**Defining High Bleeding Risk in Patients Undergoing Percutaneous Coronary Intervention**

A Consensus Document From the Academic Research Consortium for High Bleeding Risk



Download the App





Prior MI or stent thrombosis  
Peripheral artery disease  
Recurrent ischemic events on DAPT  
Clinical presentation (ACS)  
Prior ischemic stroke

Prior bleeding/recent bleeding

*“If it were not for the great variability among individuals, medicine might as well be a science and not an art”*

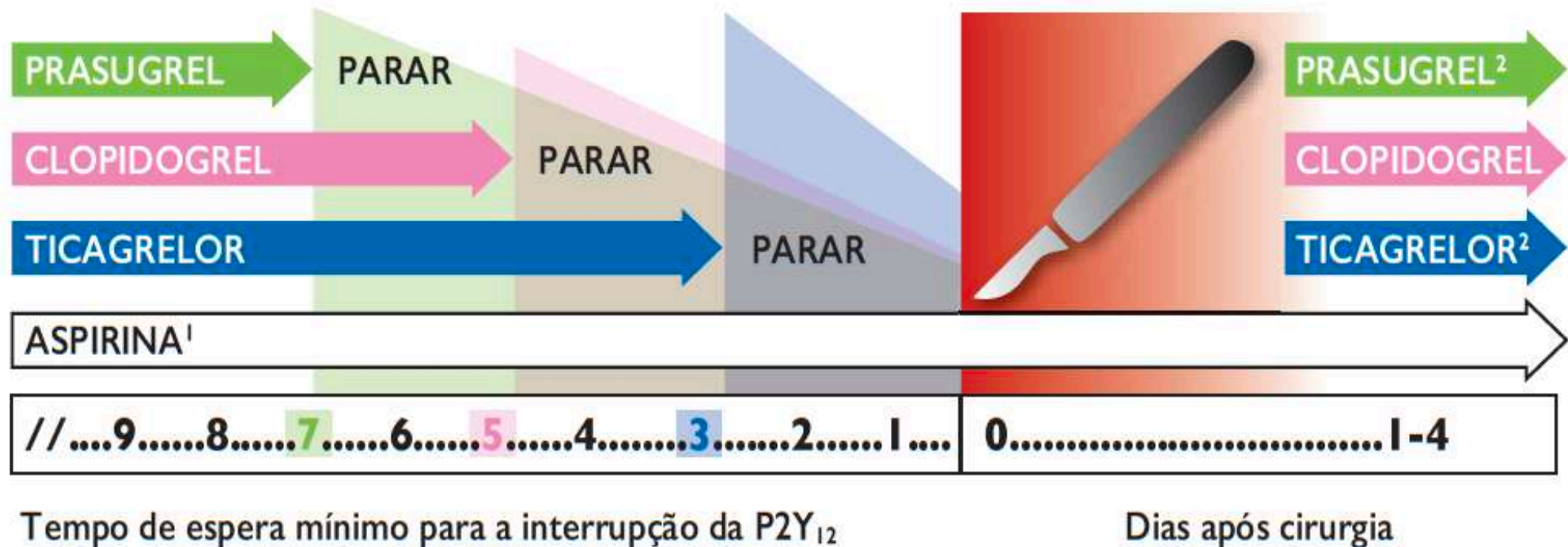
**Sir William Osler (1849-1919)**

first generation DES



# DAPT e Cirurgia

**Figura 9** Descontinuação mínima e calendarização da reimplantação da terapêutica antiagregante plaquetária dupla (TAPD) nos doentes submetidos a cirurgia eletiva



<sup>1</sup>A decisão de interromper a aspirina ao longo da cirurgia deve ser tomada individualmente tendo em consideração o risco hemorrágico cirúrgico.  
<sup>2</sup>Em doentes que não necessitem de ACO.

# MENSAGENS-CHAVE

Recomendações	Classe <sup>a</sup>	Nível <sup>b</sup>
Recomenda-se a melhoria dos estilos de vida em complemento de terapêutica farmacológica adequada.	I	A



## Tabela 6 Recomendações sobre o estilo de vida para os doentes com síndromes coronárias crónicas

### Fator estilo de vida

#### Cessaçãotabágica

Utilizar estratégias farmacológicas e comportamentais para ajudar os doentes a deixar de fumar. Evitar o tabagismo passivo.

#### Dieta saudável

Dieta rica em vegetais, fruta, cereais integrais. Limitar a gordura saturada para < 10% do total. Limitar a ingestão de bebidas alcoólicas para < 100 g/ semana ou 15 g/dia.

#### Atividade física

Atividade física moderada 30 - 60 min na maioria dos dias, sendo mesmo assim, benéfica, a atividade física irregular.

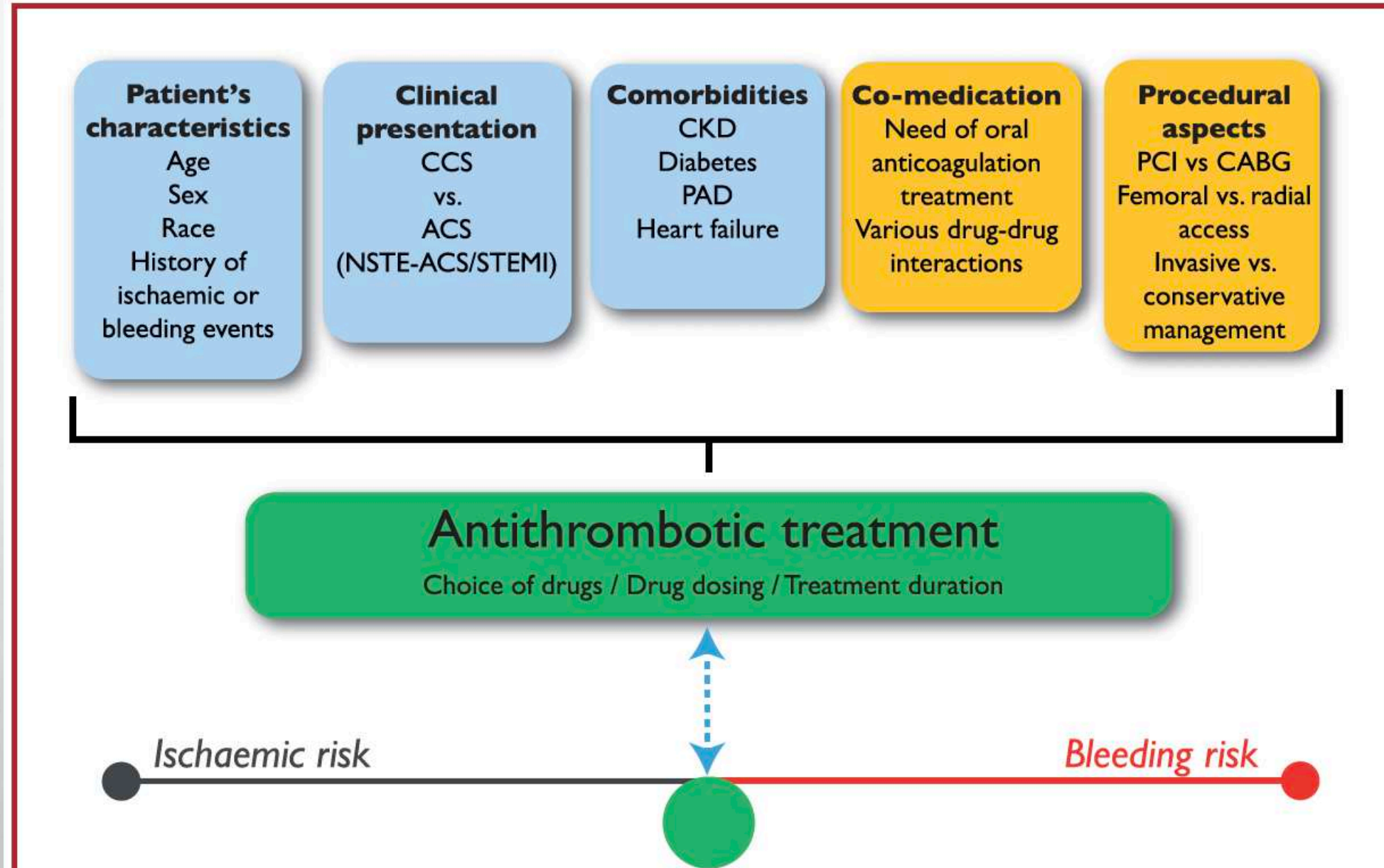
#### Peso saudável

Obter e manter um peso saudável (< 25 kg/m<sup>2</sup>) ou reduzir o peso através de ingestão calórica recomendada e de incrementação da atividade física.

#### Outros

Tomar a medicação conforme a prescrição médica. A atividade sexual constitui um risco baixo para os doentes estáveis não sintomáticos com níveis de atividade baixos a moderados.

# Determinantes da Terapêutica Antitrombótica



# Duração da DAPT



*“the shorter, the better”*



*What’s the best strategy:*

- *Medically managed*
- *After CABG*

## **non-ACS PCI**

*1-3 months DAPT followed by P2Y12 inhibitor monotherapy (with ticagrelor if tolerated)*

## **ACS**

*3 months DAPT if high bleeding risk  
3 months DAPT + tica possible in selected NSTEMI  
12 months DAPT in STEMI wt HBR*

# Duração da DAPT



*“the longer, the better”*

*Multivessel disease (ACS)  
Polivascular disease  
Diabetes (ACS)  
Recurrent events  
Complex anatomy/PCI*



***Don't prolong if HBR***  
*(check ARC-HBR criteria)*

# TABELA RESUMO

**Table 2. Suggested Approaches to Antithrombotic Treatment after an ACS Event.\***

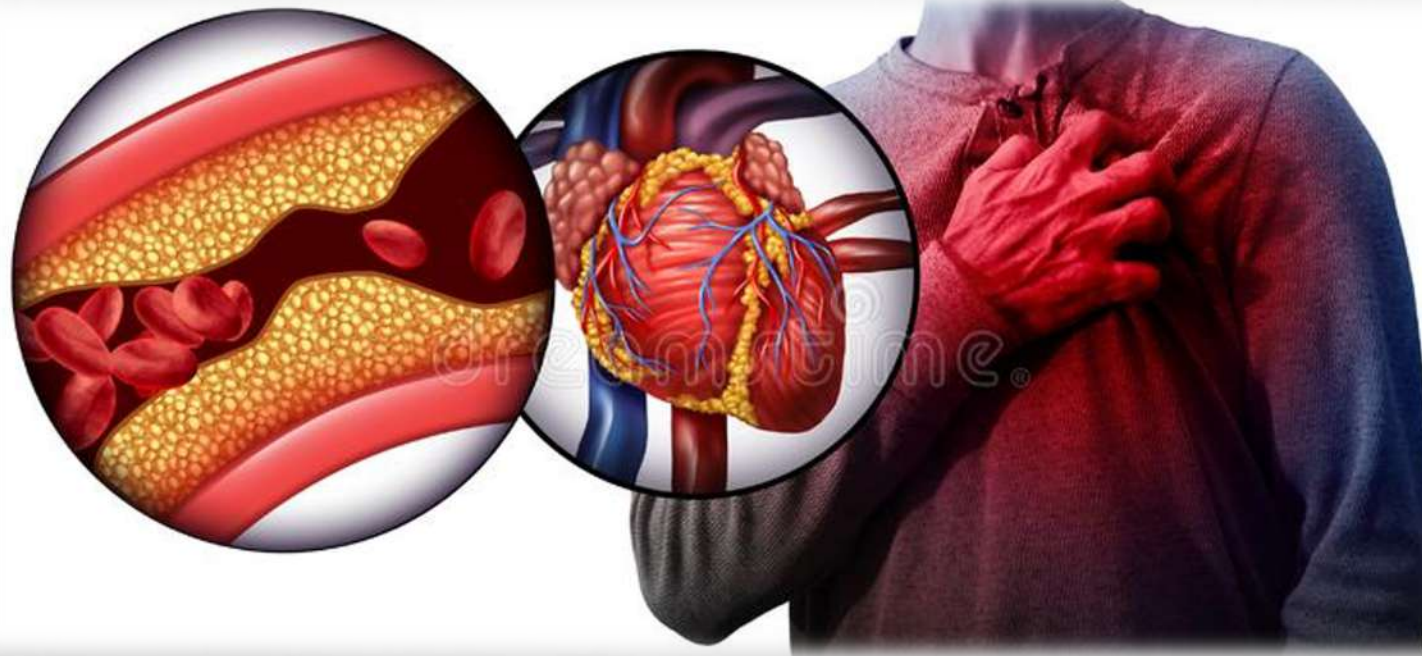
Time after ACS Event	Default Strategy	Patients with High Ischemic Risk	Patients with High Bleeding Risk	Patients with Concomitant Atrial Fibrillation†
≤1 mo	Aspirin and newer-generation P2Y <sub>12</sub> inhibitor	Aspirin and newer-generation P2Y <sub>12</sub> inhibitor	Aspirin and newer-generation P2Y <sub>12</sub> inhibitor	Aspirin, clopidogrel, and DOAC‡
>1 mo to 12 mo	Aspirin and newer-generation P2Y <sub>12</sub> inhibitor	Aspirin and newer-generation P2Y <sub>12</sub> inhibitor	Any P2Y <sub>12</sub> inhibitor alone	Clopidogrel and DOAC
>12 mo	Any P2Y <sub>12</sub> inhibitor alone	Aspirin and newer-generation P2Y <sub>12</sub> inhibitor, or switch to aspirin and low-dose rivaroxaban	Any P2Y <sub>12</sub> inhibitor or aspirin	DOAC

\* Aspirin is given at a dose of less than 100 mg. In this table, prasugrel and ticagrelor are considered newer-generation P2Y<sub>12</sub> inhibitors. ACS denotes acute coronary syndrome, and DOAC direct oral anticoagulant.

† Recommendations are for patients with nonvalvular atrial fibrillation (those who do not have mechanical heart valves and do not have moderate-to-severe mitral stenosis).

‡ Consider withdrawing aspirin before hospital discharge for patients who are at high risk for bleeding.

# OBRIGADA!



**Orientador: Dr. Gomes Serrão**  
**Diretor de Serviço: Dr. Drumond Freitas**