Prise en charge du patient en fibrillation atriale et syndrome coronarien aigu

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IMCVO Hôpital privé de Parly 2
20èmes RENCONTRES MÉDICO-CHIRURGICALES
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IMCVO Institut des Maladies Cardio-Vasculaires de l'Ouest
Journée Yves Guérin

Disclosures

Speaker: Nicolas Meneveau

☑ I have the following potential conflicts of interest to declare:

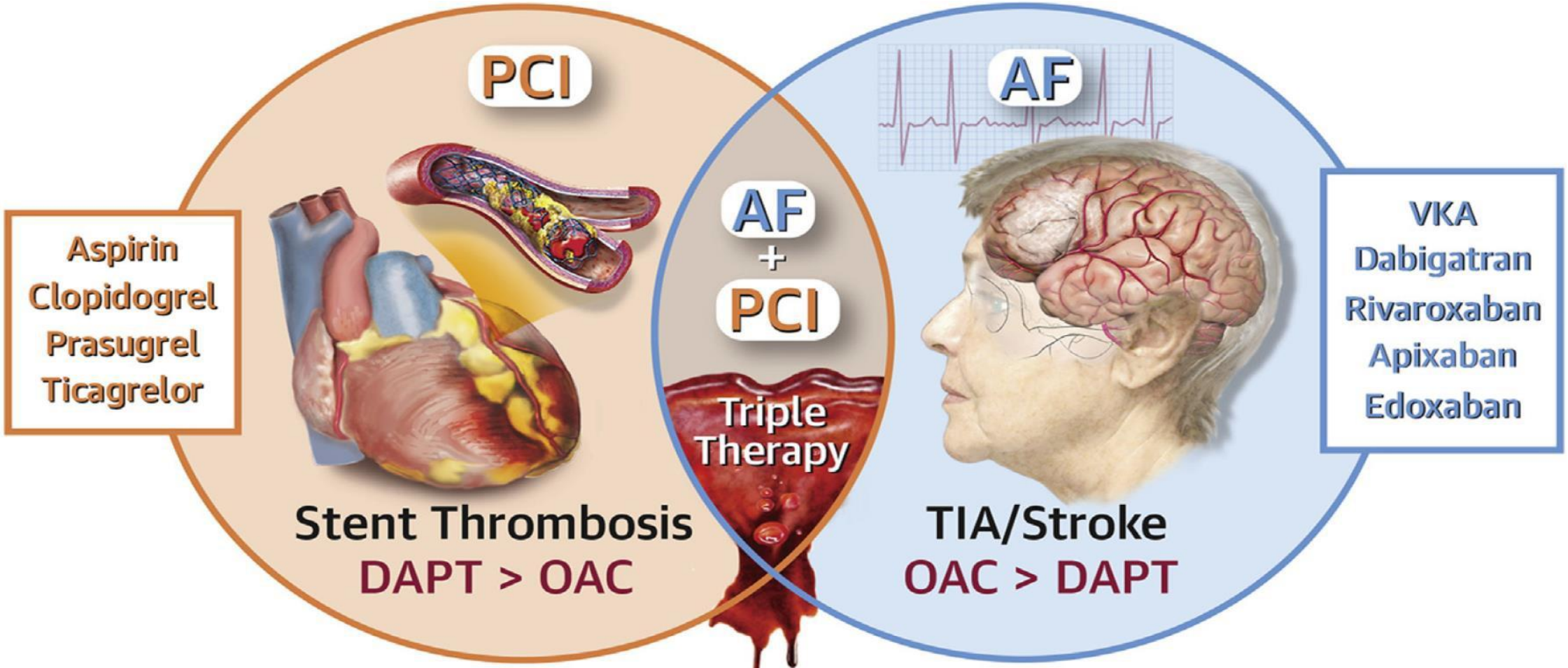
Consultant:

Abbott, Alliance BMS/Pfizer, Bayer, Bayer Healthcare, Edwards Lifesciences, Sanofi Regeneron, Terumo

Honoraria:

AstraZeneca

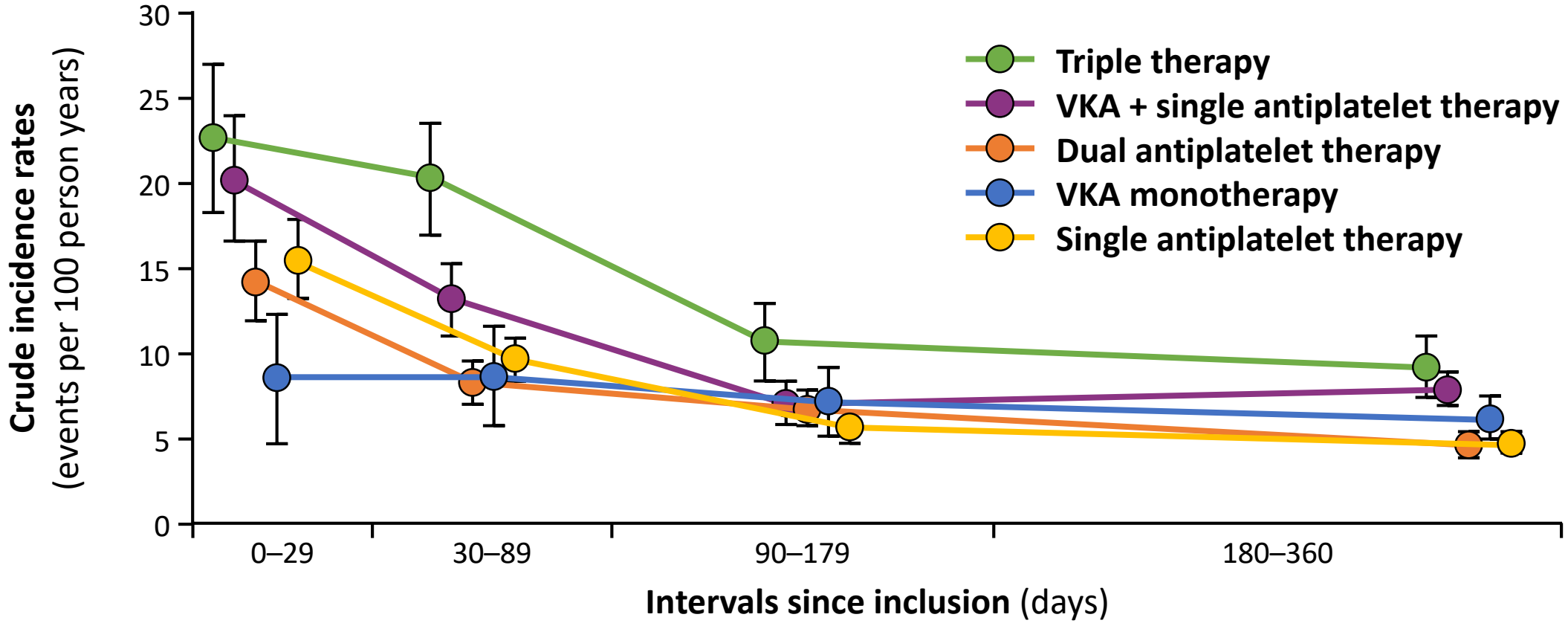
Clinical challenge in patients with atrial fibrillation undergoing PCI



Schömig et al. NEJM 1996. Connolly et al Lancet 2006.
Capodanno D, Angiolillo DJ. JACC: Cardiovascular Interventions 2017.

Bleeding and triple therapy after ACS/PCI in patients with atrial fibrillation

A nationwide cohort study

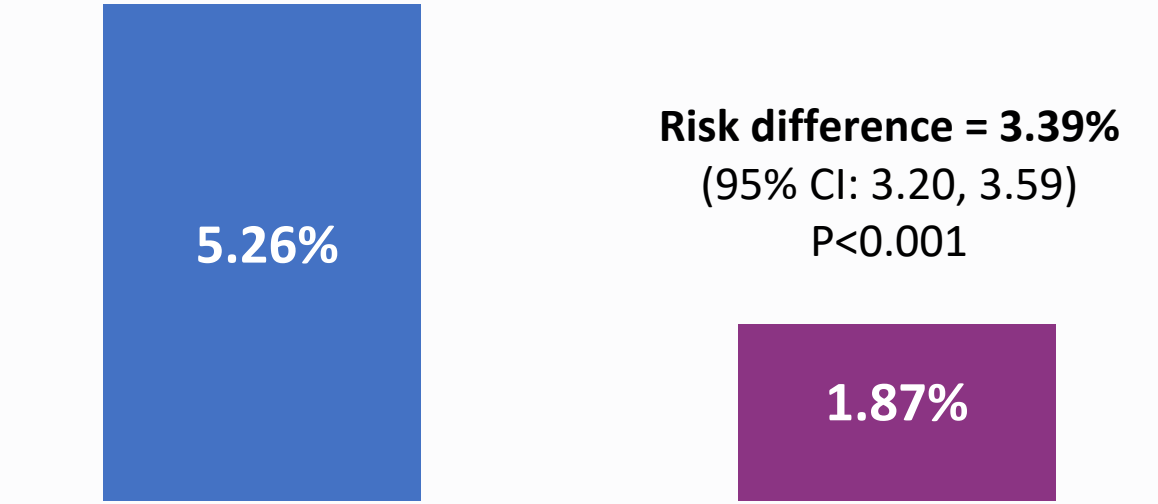


Lamberts, et al. Circulation 2012;126:1185–93.

For patients undergoing PCI, major bleeding is associated with increased in-hospital mortality

Data from 3,386,688 procedures in the CathPCI Registry in the US 2004-2011

Bleeding represents the most common non-cardiac complication of PCI



In-hospital mortality rate:
Major bleeding

Risk difference = 3.39%
(95% CI: 3.20, 3.59)
P<0.001

In-hospital mortality rate:
Non-bleeding

12.1% of deaths related to bleeding complications

CI, confidence interval; PCI, percutaneous coronary intervention.

Chatriwalla AK, et al. JAMA 2013;309:1022–9.

Combinations of antiplatelet and antithrombotic agents in patients with AF and stent placement

2.8 million different combinations!

ASA dose	None	Low	High				2	**1+8 = 9 ASA**
ASA duration, months	1	3	6	12			4	
Thienopyridine	None	Clop	Ticlo	Pras	Ticag		4	**1+16 = 17 Thieno**
Thienopyridine duration, months	1	3	6	12			4	
AC	None	Warf	Dabi	Riva	Apix	Edox	5	**1+10 = 11 ACs**
AC INR/dose		Low	High				2	

Permutations of single, dual or triple therapy as **early initial therapy (0, 1, 3, 6 months)** following ACS: **9 x 17 x 11 = 1,683**

Permutations of single or dual therapy **late after early therapy (0, 1, 3, 6, 12 months)** following ACS: **1,683**

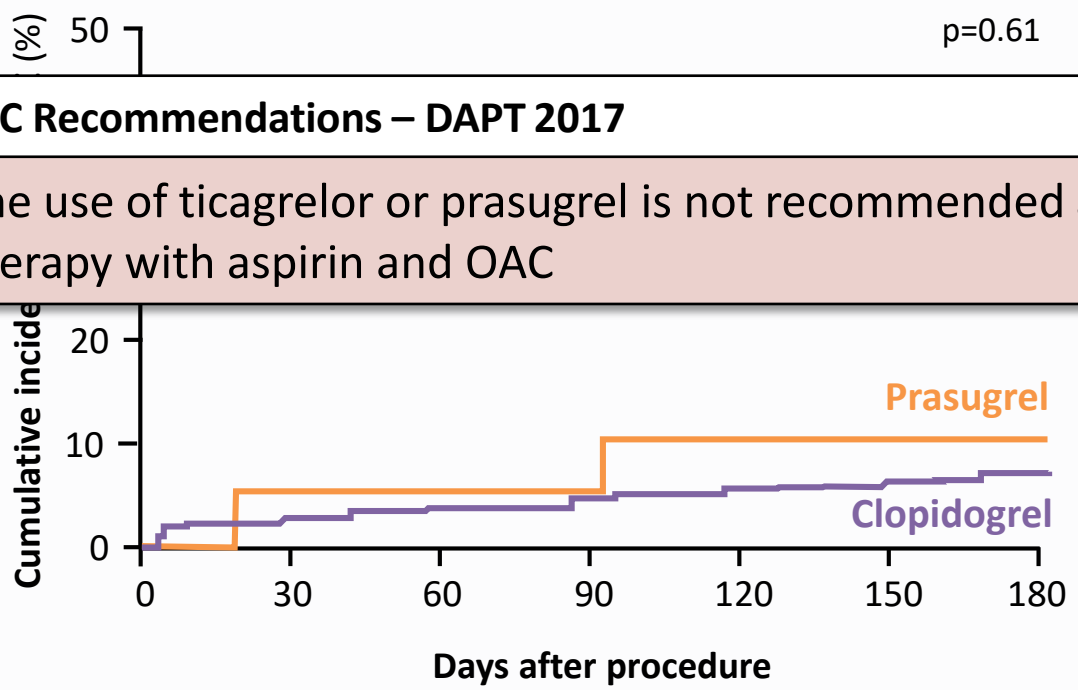
Total permutations *throughout one year:* 2.8 million

Gibson CM. JACC 2017;69:172–5.

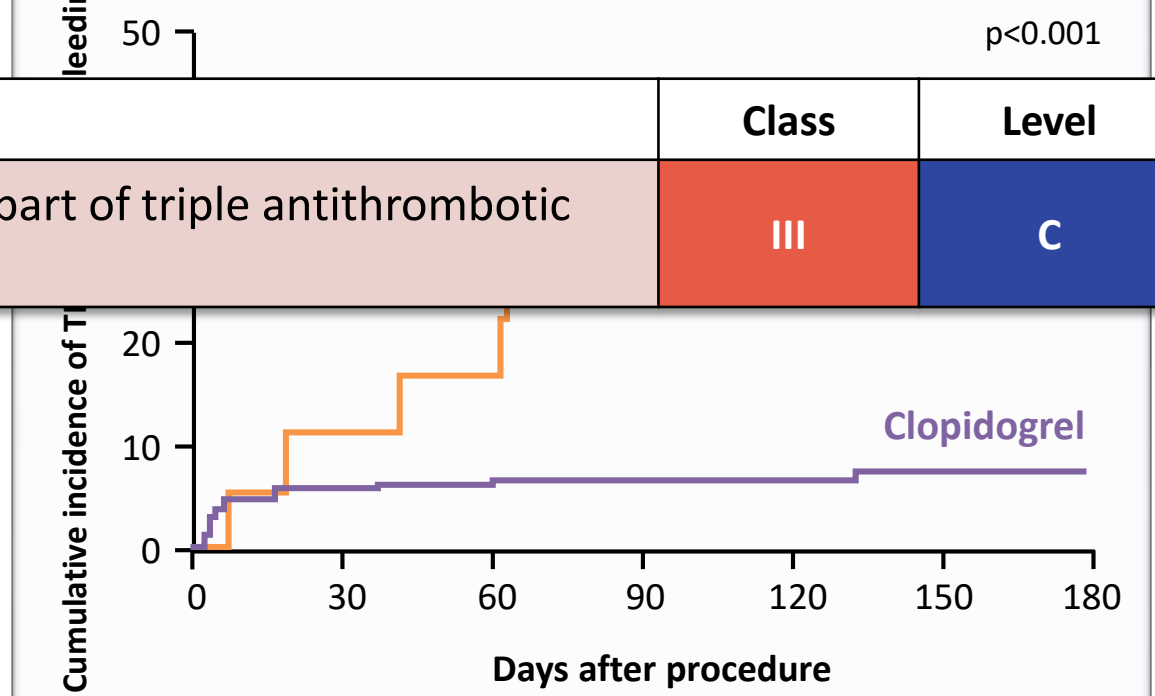
Triple therapy with aspirin, prasugrel and VKA after DES implantation

377 consecutive pts (2009–2011) with an indication for OAC treated with a 6-month regimen of aspirin and either prasugrel (N=21) or clopidogrel (N=356)

Death, MI, stroke or ST



TIMI bleeding



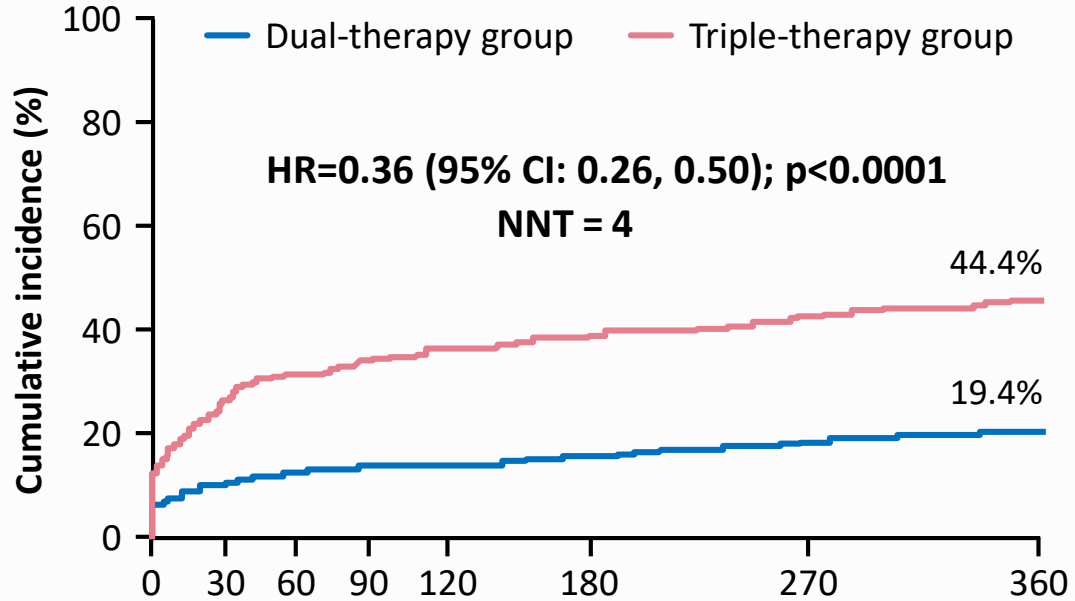
ESC Recommendations – DAPT 2017	Class	Level
The use of ticagrelor or prasugrel is not recommended as part of triple antithrombotic therapy with aspirin and OAC	III	C

Sarafoff N, et al. J Am Coll Cardiol 2013;61:2060–6.

WOEST : Trial results

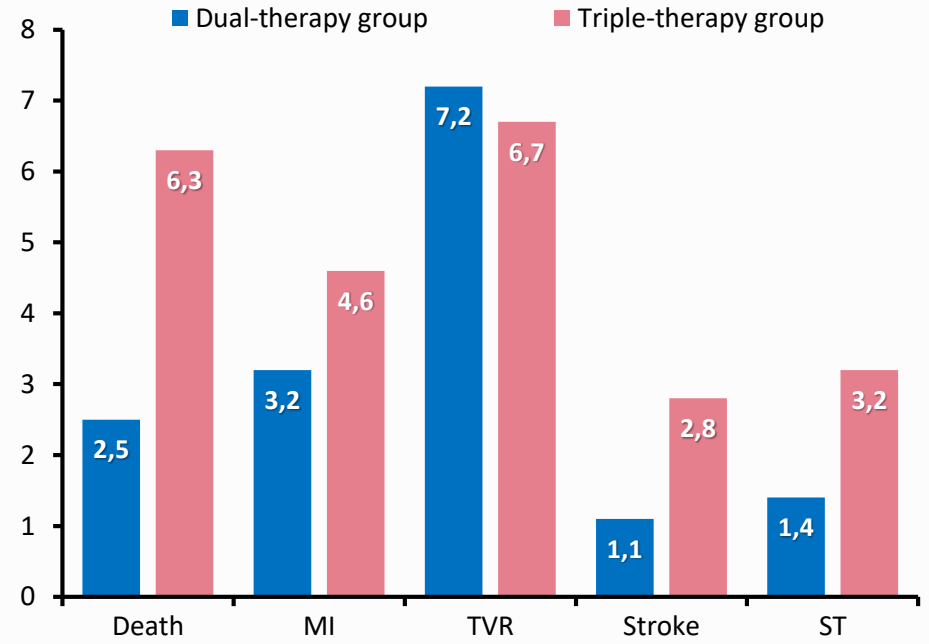
573 patients on OAC undergoing stent (DES/BMS) implantation received oral anticoagulants* + clopidogrel 75 mg qd** and randomised 1:1 to also receive aspirin 80 mg OR aspirin placebo qd

Primary endpoint: any bleeding



Number at risk								
Triple therapy	284	210	194	186	181	173	159	140
Double therapy	279	253	244	241	241	236	226	208

Secondary endpoint: ischaemic events



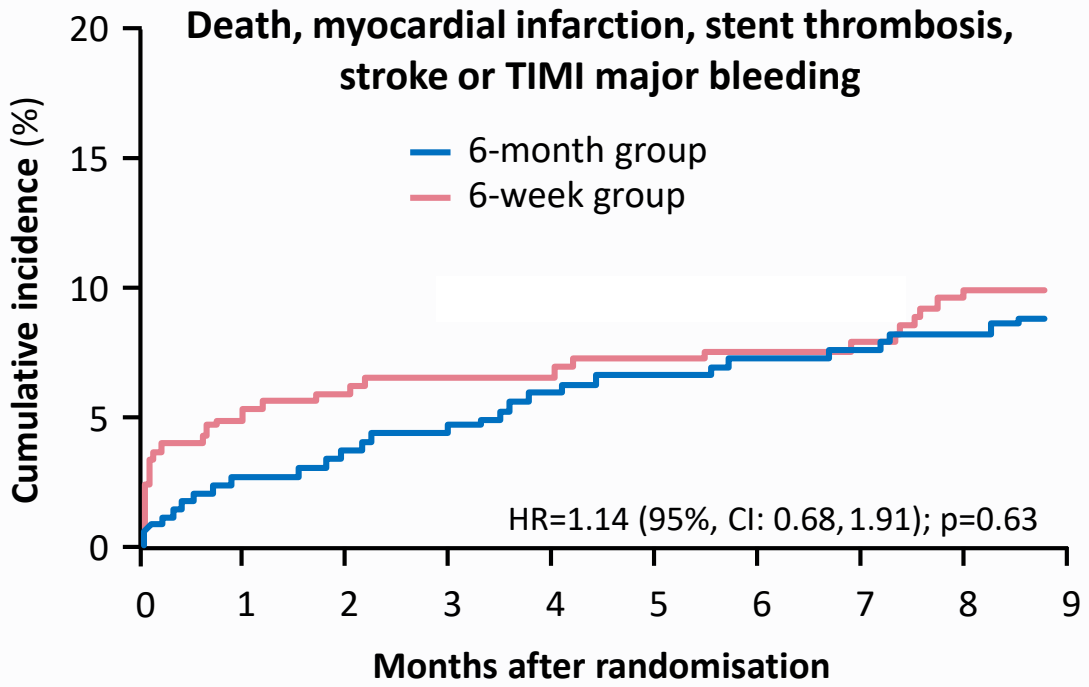
Dewilde W, et al. Lancet 2013;381:1107–15.

ISAR-TRIPLE : Trial results

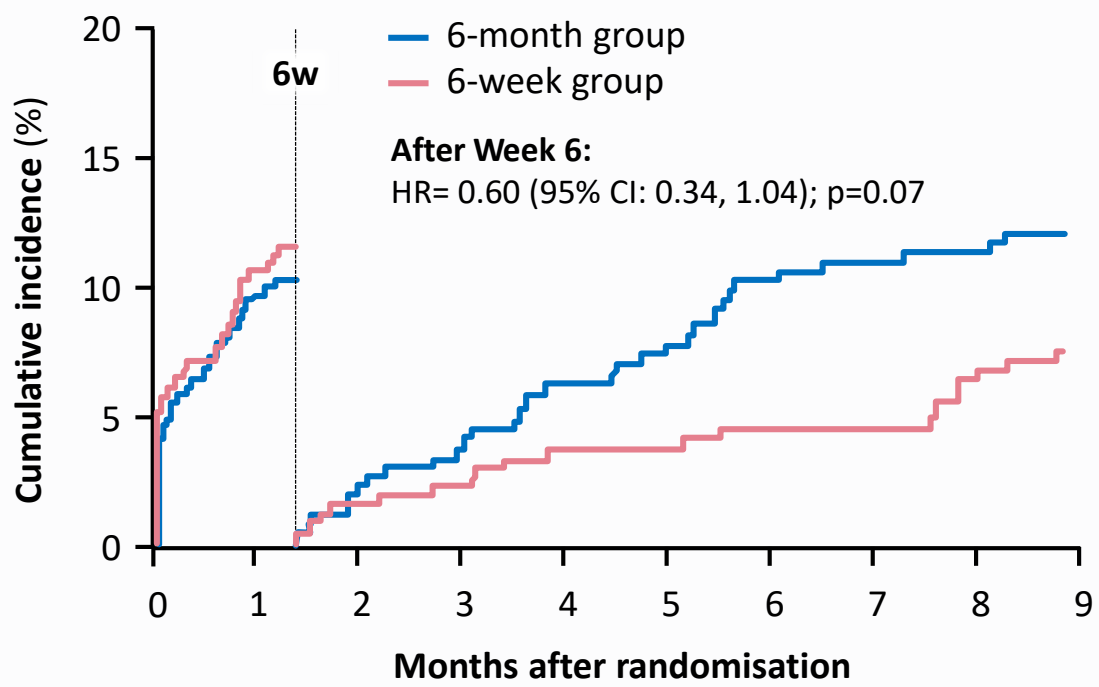
Duration of triple therapy in 600 Pts requiring oral anticoagulation after DES implantation

6-week vs 6-month triple therapy (1:1 randomisation)

Primary endpoint



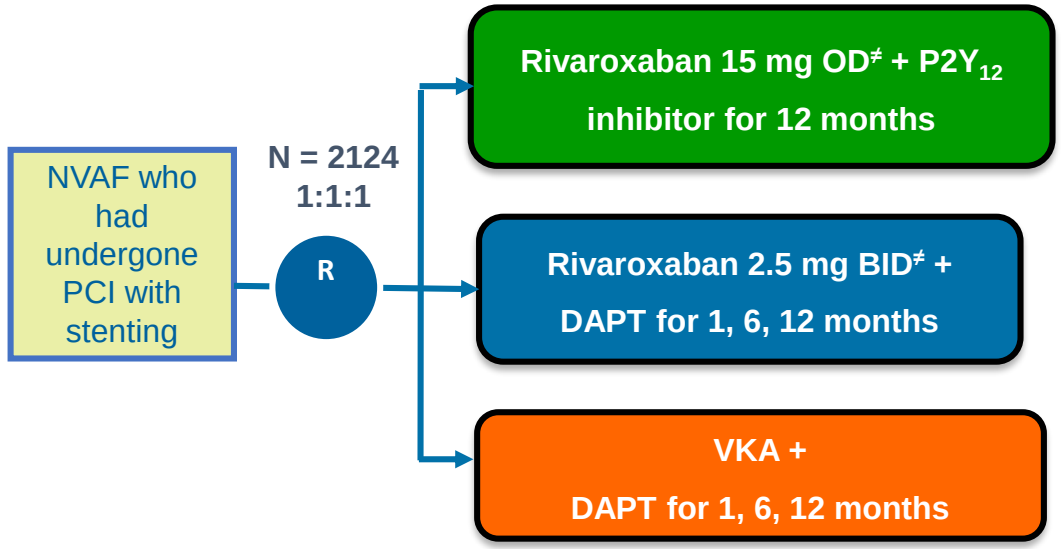
BARC ≥2



Fiedler KA, et al. J Am Coll Cardiol 2015;65:1619–29.

Safety and efficacy of dual vs. triple antithrombotic therapy in patients with AF following PCI

PIONEER AF-PCI[1]

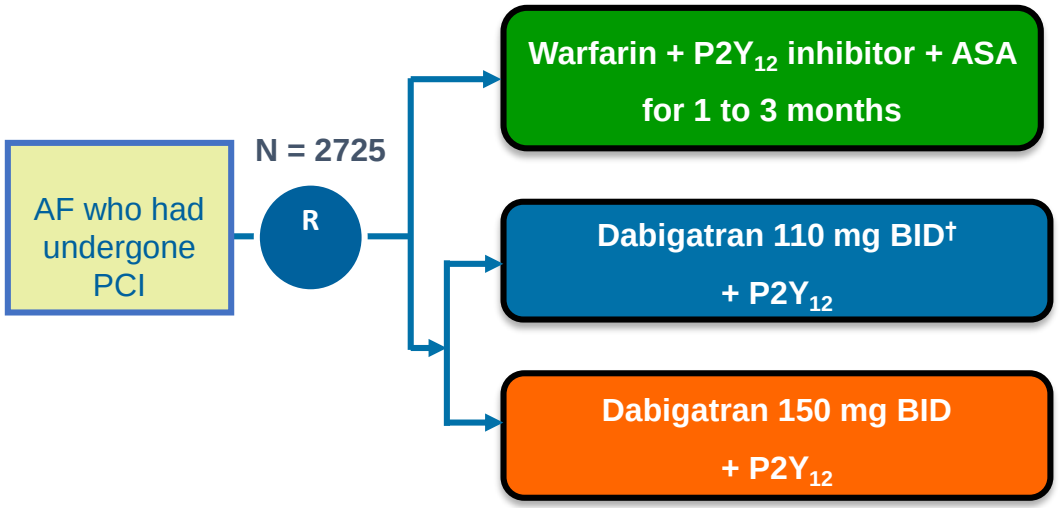


In PIONEER AF-PCI[2] $P2Y_{12}$ = clopidogrel, prasugrel, or ticagrelor

PIONEER AF-PCI[1] demonstrated significantly less bleeding in either rivaroxaban containing arm compared to VKA plus DAPT.

In patients where DAPT (ASA + $P2Y_{12}$) was received for < 12 months SAPT (ASA) was given instead

RE-DUAL PCI[2]



In RE-DUAL[3] $P2Y_{12}$ = clopidogrel or ticagrelor

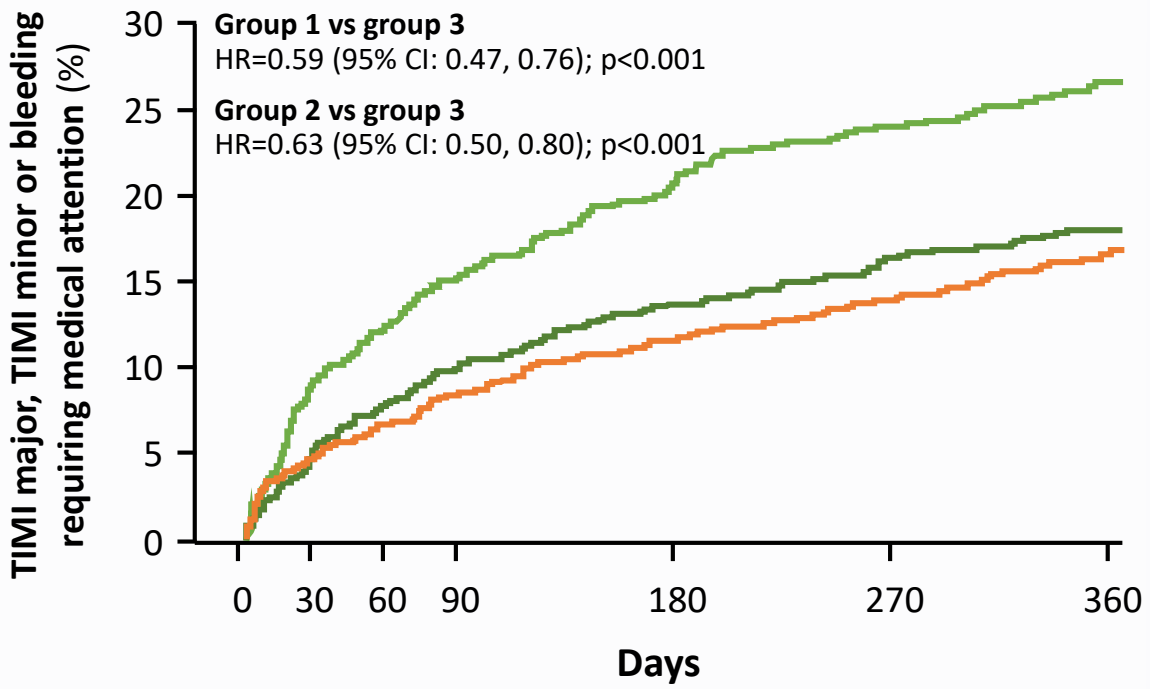
RE-DUAL PCI[2] demonstrated significantly less major or CRNM bleeding in each of the dabigatran strategies compared to the VKA strategy.

1.Adapted from Gibson CM et al. *N Engl J. Med.* 2016;375:2423-2434
2.Adapted from Cannon CP et al. *N Engl J. Med.* 2017;377:1513-1524

Pioneer AF-PCI : Primary safety and secondary efficacy endpoints

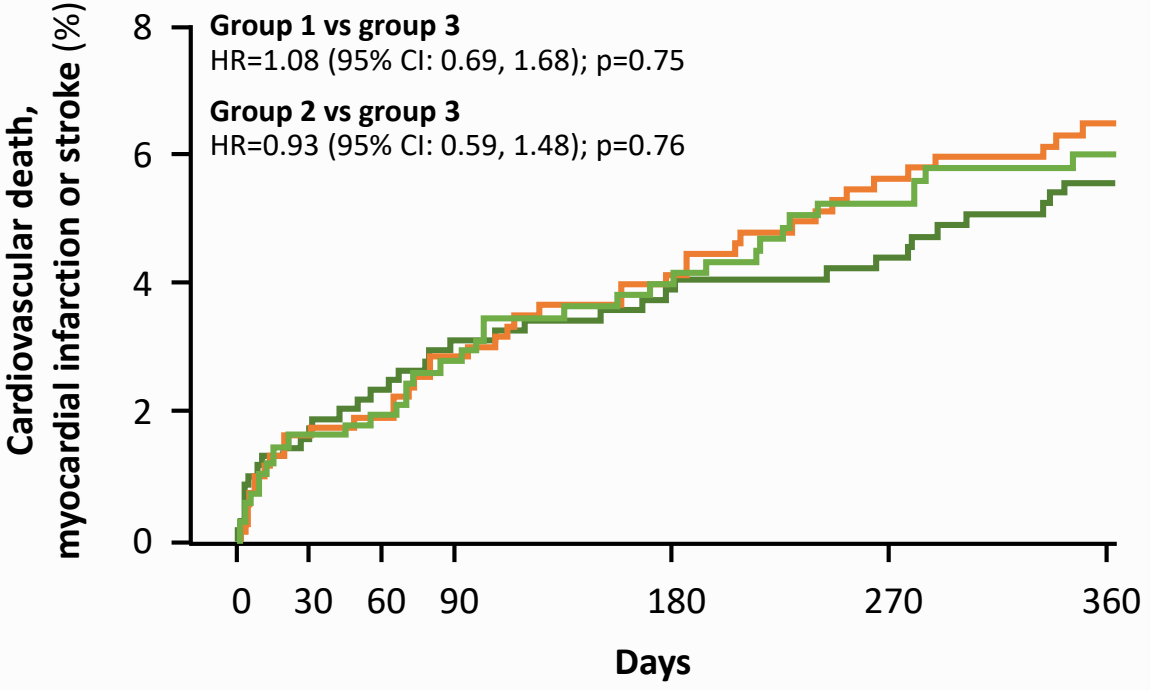
Primary safety endpoint

Clinically relevant TIMI bleeding
(major, minor bleeds requiring medical attention)



Secondary efficacy endpoint

CV death, MI or stroke



Group 1 : VKA + DAPT — **Group 2** : Rivaroxaban + DAPT — **Group 3** : Rivaroxaban + $P2Y_{12}$

Gibson CM, et al. N Engl J Med 2016;375:2423–34.

PIONEER : Cumulative incidence of secondary outcomes

	Riva 15 mg + $P2Y_{12}$ inh (grp1) N = 694	Riva 2.5 mg + DAPT (grp 2) N = 704	Warfarin + DAPT (grp3) N = 695	Group 1 vs Group 3	Group 2 vs Group 3
	N (%)	N (%)	N (%)	HR (95% CI)	HR (95% CI)
CV death	15 (2.4)	14 (2.2)	11 (1.9)	1.29 (0.59–2.8)	1.19 (0.54–2.62)
Stroke	8 (1.3)	10 (1.5)	7 (1.2)	1.07 (0.39–2.96)	1.36 (0.52–3.58)
MI	19 (3.0)	17 (2.7)	21 (3.5)	0.86 (0.46–1.59)	0.75 (0.40–1.42)
Stent thrombosis	5 (0.8)	6 (0.9)	4 (0.7)	1.20 (0.32–4.45)	1.44 (0.40–5.09)

Use of NOACs was not associated with increased cardiovascular outcomes compared with VKA

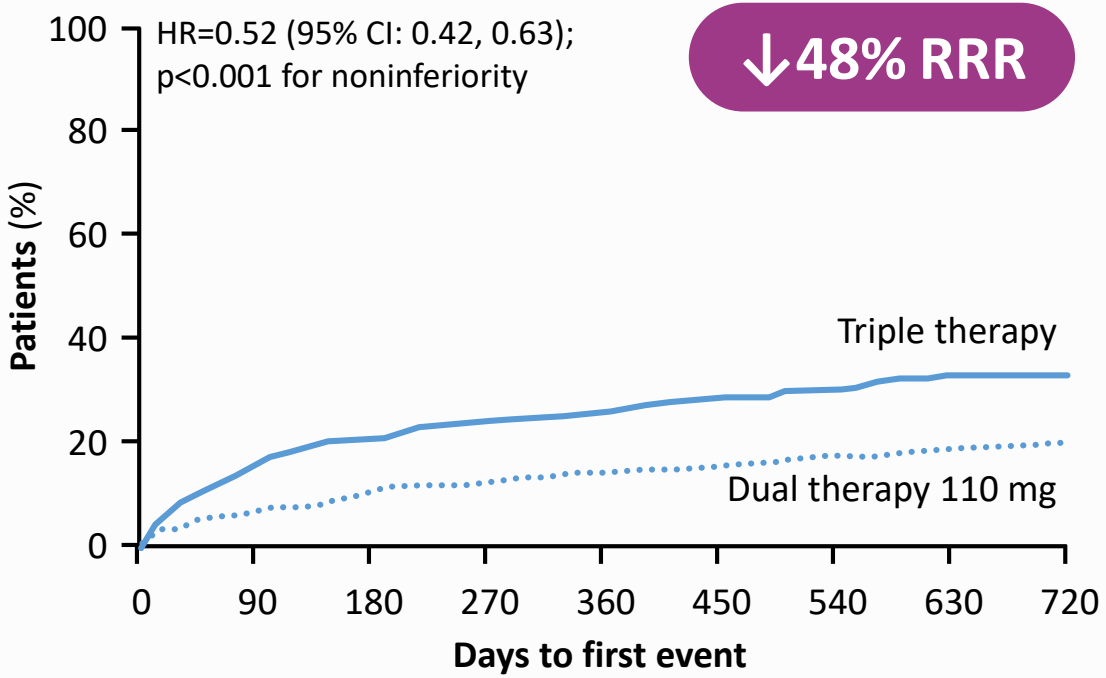
CV, cardiovascular; DAPT, dual antiplatelet therapy; MI, myocardial infarction.

Gibson et al. N Engl J Med 2016;375:2423–34.

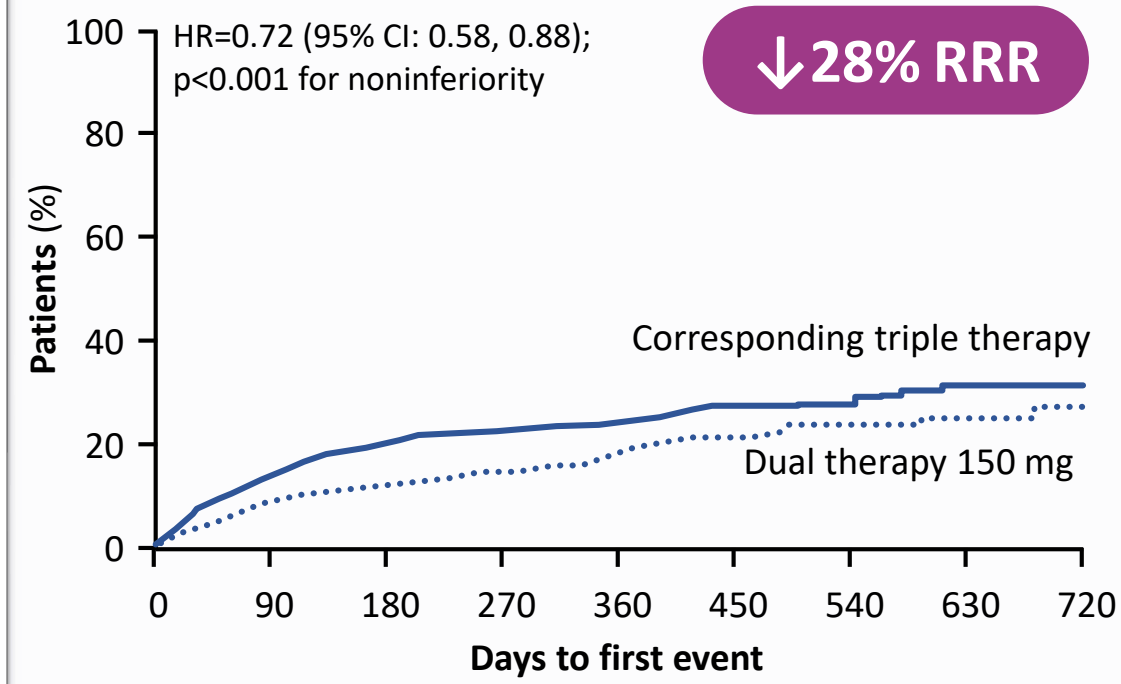
RE-DUAL PCI : Major or clinically relevant bleeding

2,725 patients with atrial fibrillation undergoing PCI

Dual therapy (110 mg) vs triple therapy



Dual therapy (150 mg) vs triple therapy

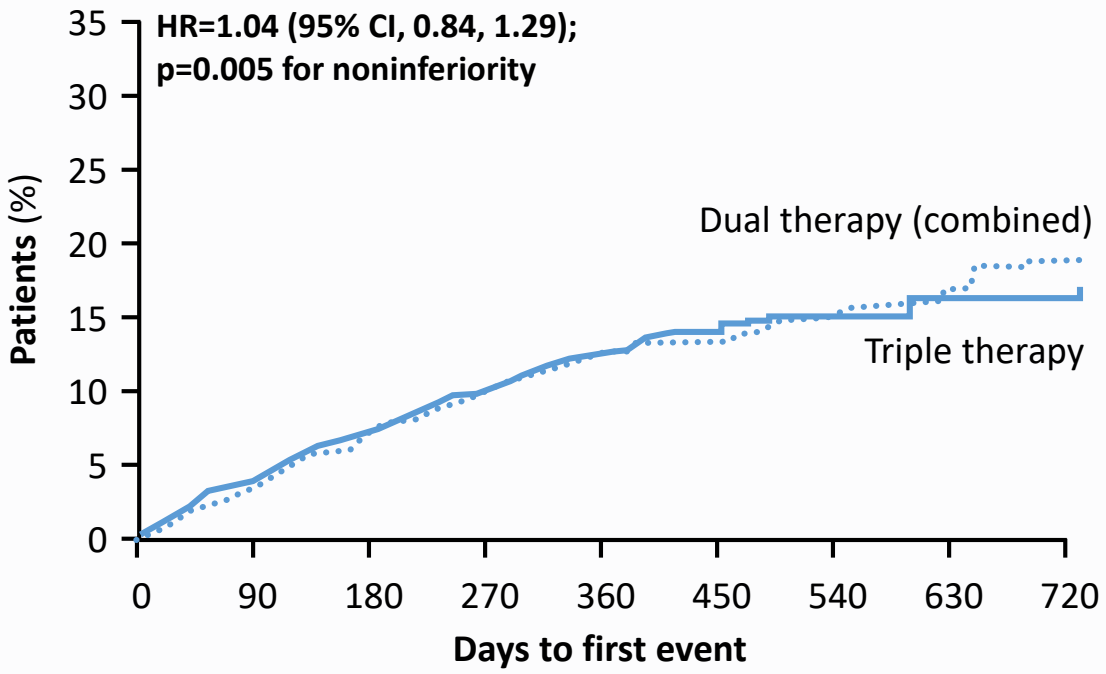


RRR, relative risk reduction.

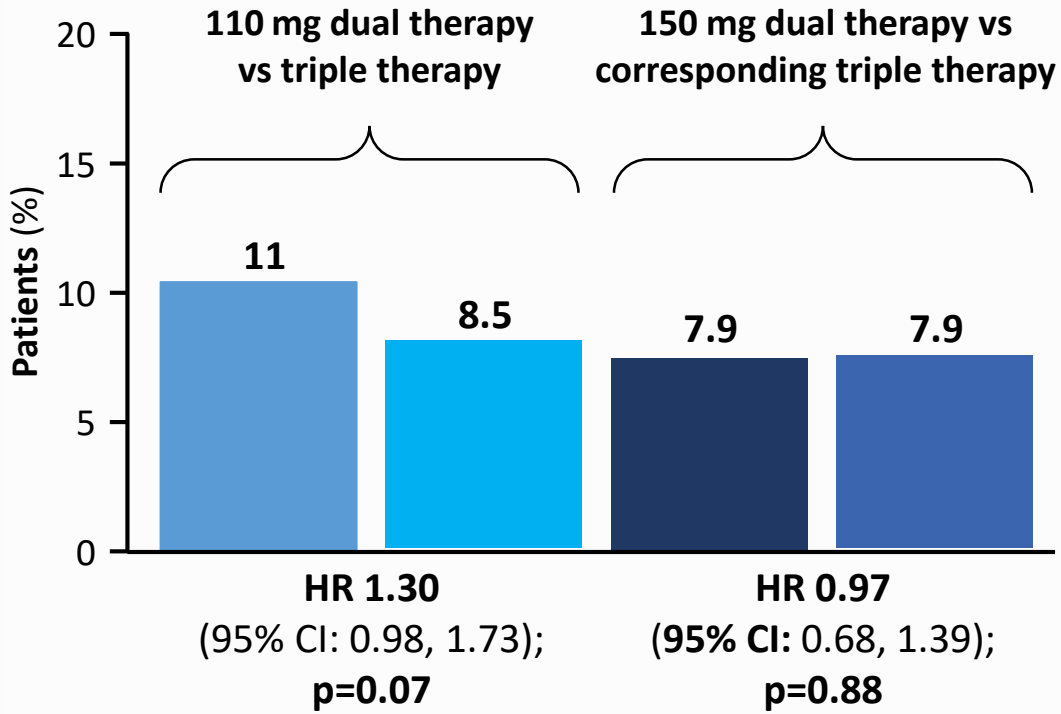
Cannon C, et al. N Engl J Med 2017;377:1513–24.

RE-DUAL PCI : Secondary efficacy endpoints

Thromboembolic events (MI, stroke, systemic embolism), death or unplanned revascularisation



Thromboembolic events (MI, stroke, systemic embolism) or death



Cannon C, et al. N Engl J Med 2017;377:1513–24.

RE-DUAL : What about MACEs ?
Incidence of selected secondary efficacy outcomes

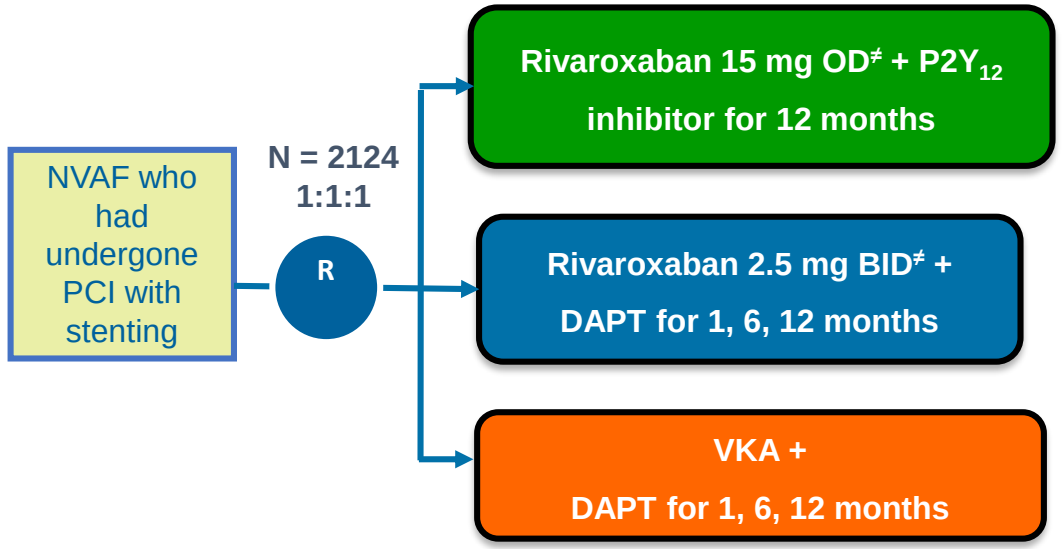
	Dual therapy with dabigatran (110 mg) vs triple therapy with warfarin			Dual therapy with dabigatran (150 mg) vs triple therapy with warfarin		
	110 mg dual therapy N=981	Triple therapy N=981	HR (95% CI)	150 mg dual therapy N=763	Triple therapy N=764	HR (95% CI)
	N (%)	N (%)		N (%)	N (%)	
Death	55 (5.6)	48 (4.9)	1.12 (0.76–1.65)	30 (3.9)	35 (4.6)	0.83 (0.51–1.34)
Stroke	17 (1.7)	13 (1.3)	1.30 (0.63–2.67)	9 (1.2)	8 (1.0)	1.09 (0.42–2.83)
MI	44 (4.5)	29 (3.0)	1.51 (0.94–2.41)	26 (3.4)	22 (2.9)	1.16 (0.66–2.04)
Definite stent thrombosis	15 (1.5)	8 (0.8)	1.86 (0.79–4.40)	7 (0.9)	7 (0.9)	0.99 (0.35–2.81)

The absolute number of stent thrombosis was low

Cannon C, et al. N Engl J Med 2017;377:1513–24.

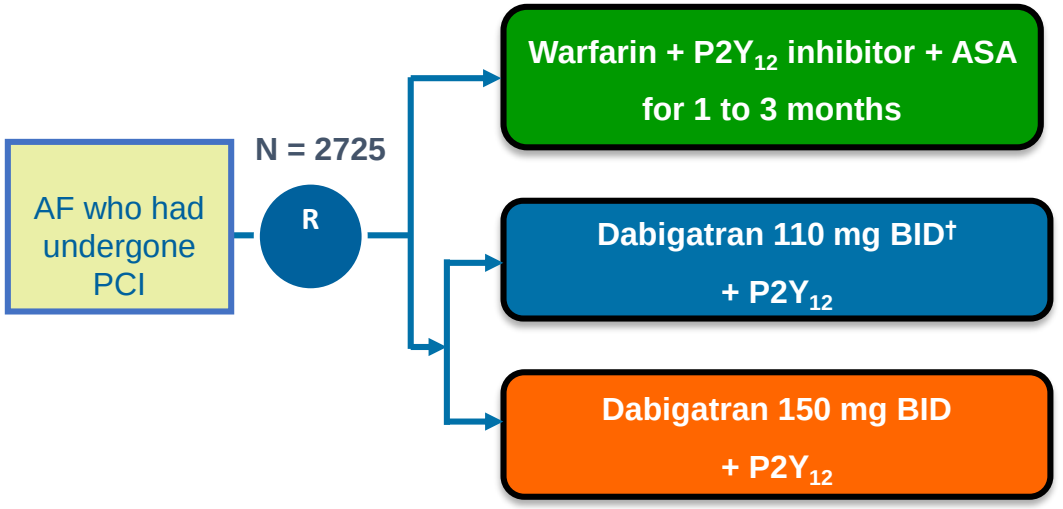
Safety and efficacy of dual vs. triple antithrombotic therapy in patients with AF following PCI

PIONEER AF-PCI[1]



In PIONEER AF-PCI[2] $P2Y_{12}$ = clopidogrel, prasugrel, or ticagrelor

RE-DUAL PCI[2]



In RE-DUAL[3] $P2Y_{12}$ = clopidogrel or ticagrelor

These trials were not powered or designed to assess whether the bleeding reduction was due to the use of a NOAC or the removal of aspirin from the post-PCI oral antithrombotic strategy.[1]

In patients where DAPT (ASA + $P2Y_{12}$) was received for < 12 months SAPT (ASA) was given instead

1.Adapted from Gibson CM et al. *N Engl J. Med.* 2016;375:2423-2434
2.Adapted from Cannon CP et al. *N Engl J. Med.* 2017;377:1513-1524

AUGUSTUS : Study design

INCLUSION

- Atrial fibrillation (prior, persistent, >6 hr)
  - Physician decision for OAC
- Acute coronary syndrome or PCI
  - Planned $P2Y_{12}$ inhibitor for ≥6 months

EXCLUSION

- Contraindication to DAPT
- Other reason for VKA (prosthetic valve, moderate/severe mitral stenosis)

Randomise
N=4,614 patients

Open label

Apixaban 5 mg BID
Apixaban 2.5 mg BID in selected patients

VKA
(INR 2–3)

$P2Y_{12}$ *inhibitor for ≥6 months*
Aspirin for all on the day of ACS and/or PCI
Aspirin versus placebo after randomisation

Aspirin — Double blind — **Placebo**

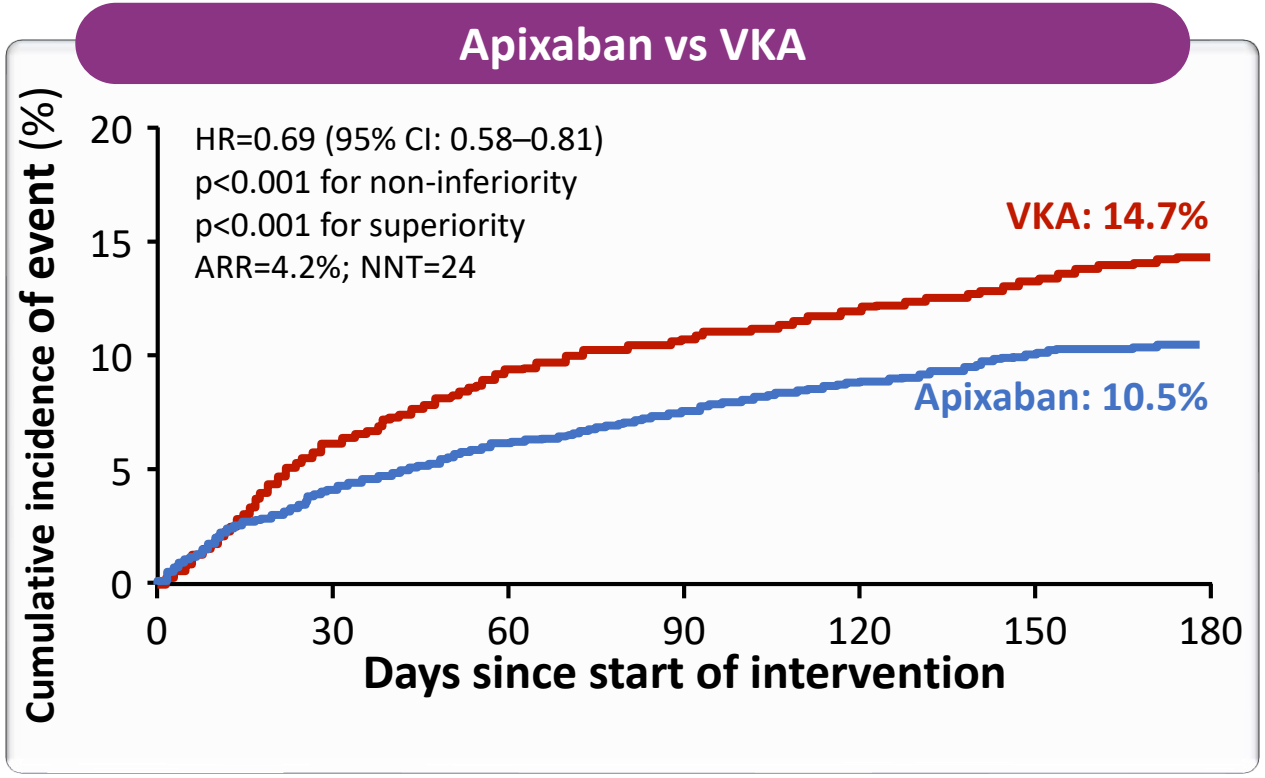
Aspirin — Double blind — **Placebo**

Primary outcome: ISTH major/CRNM bleeding
Secondary outcome(s): death/hospitalisation, death/ischaemic events

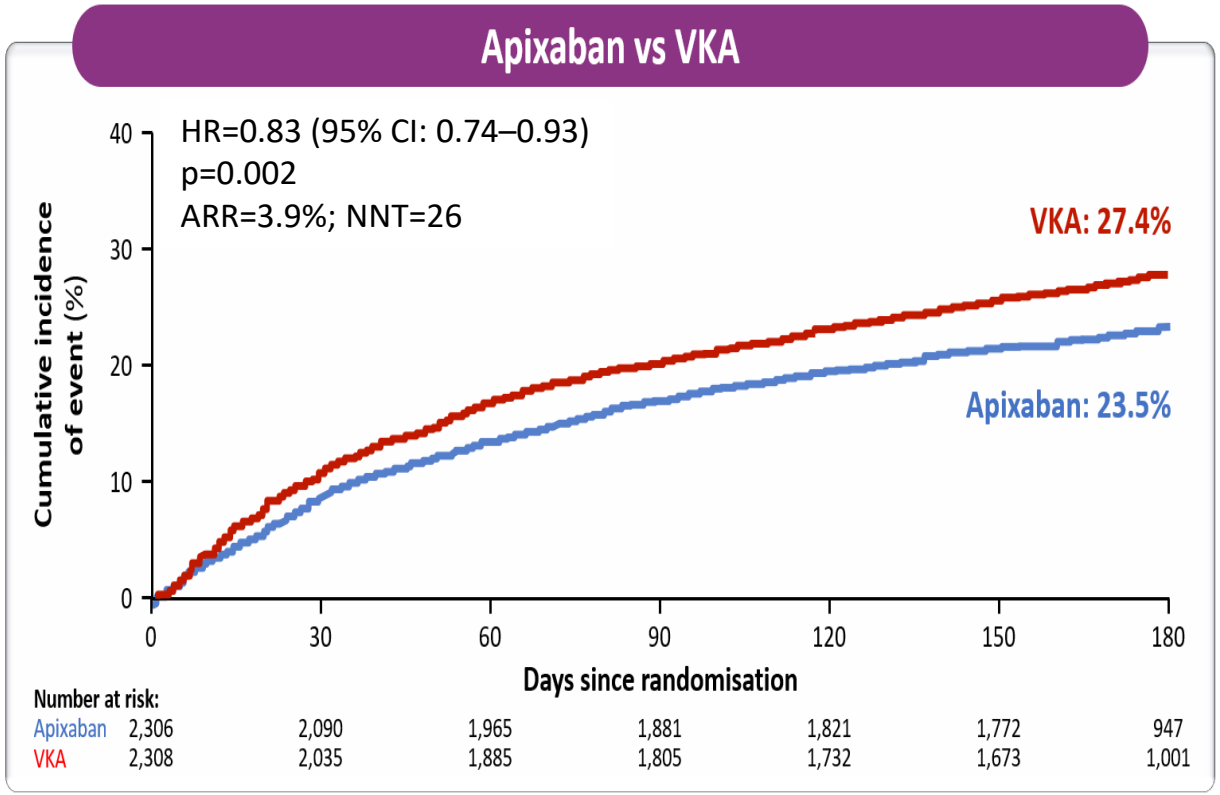
Lopes RD, et al. Am Heart J 2018;200:17-23.

AUGUSTUS primary Outcome : Apixaban vs VKA

ISTH major or CRNM bleeding



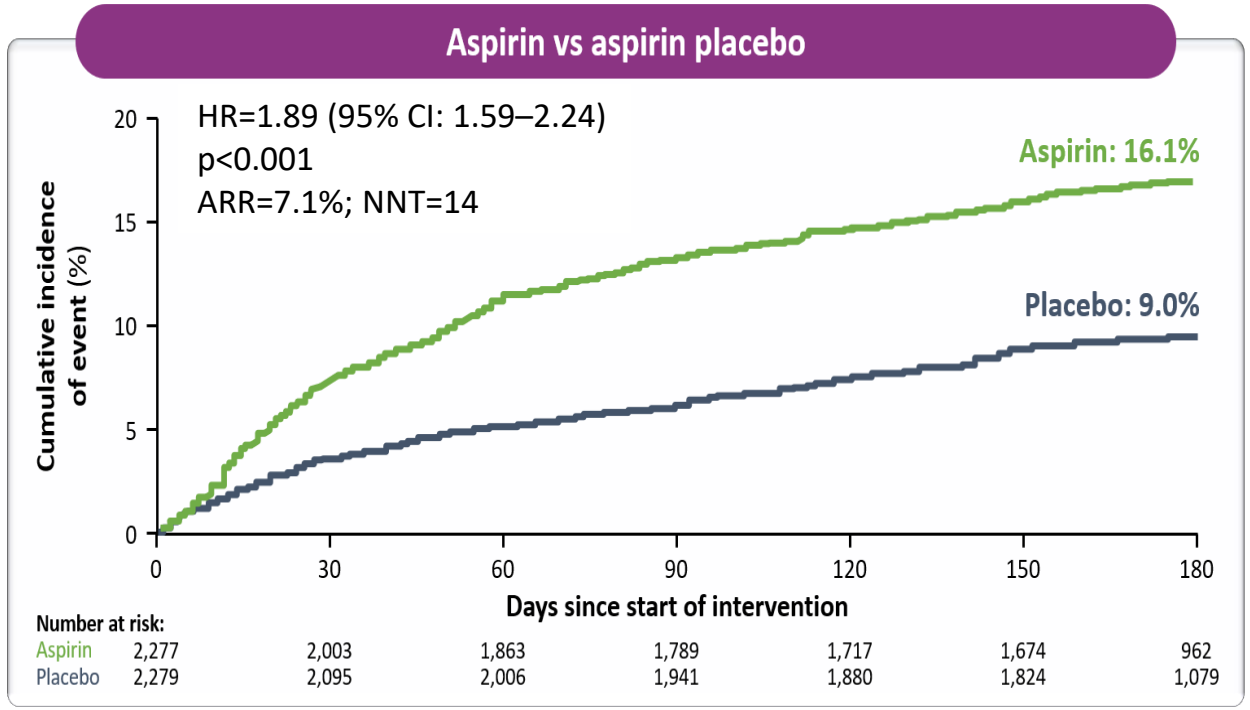
Death or hospitalization



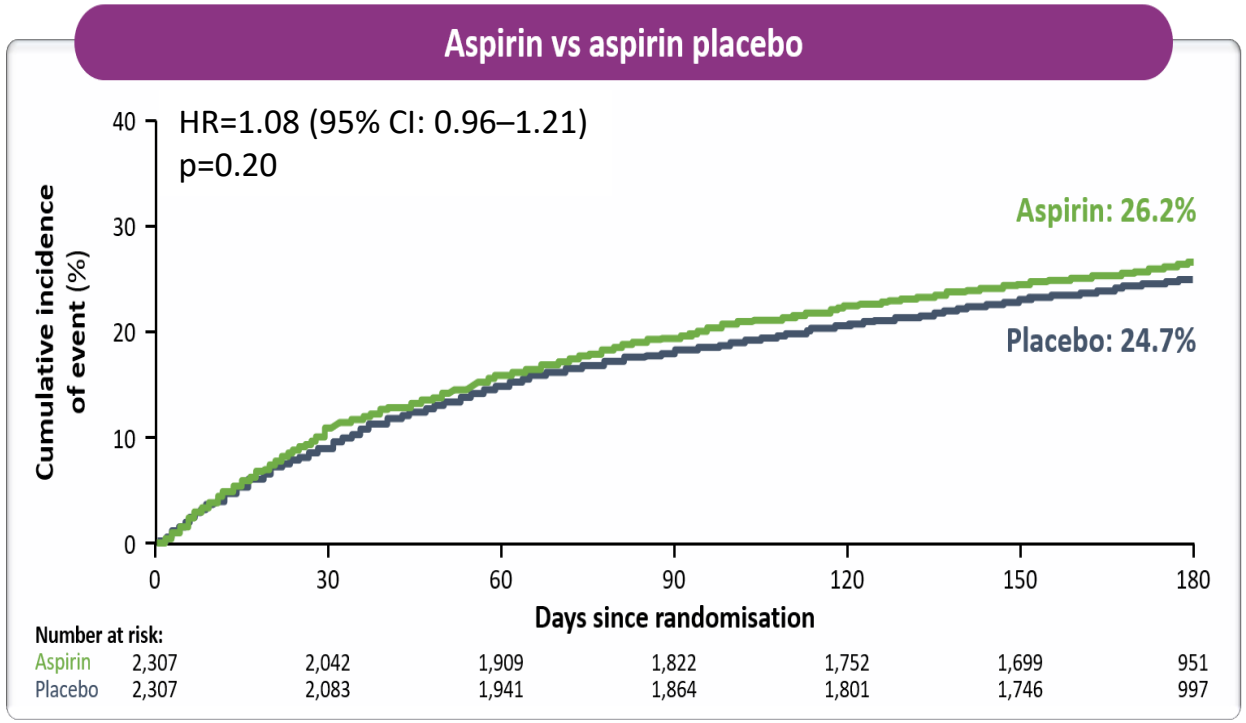
Lopes RD, et al. N Engl J Med 2019;doi:10.1056/NEJMoa1817083;
Lopes RD. Final-AUGUSTUS-Main-Results-ACC19-PRESENTATION-17-March-2019.

AUGUSTUS primary Outcome : aspirin vs placebo

ISTH major or CRNM bleeding



Death or hospitalization

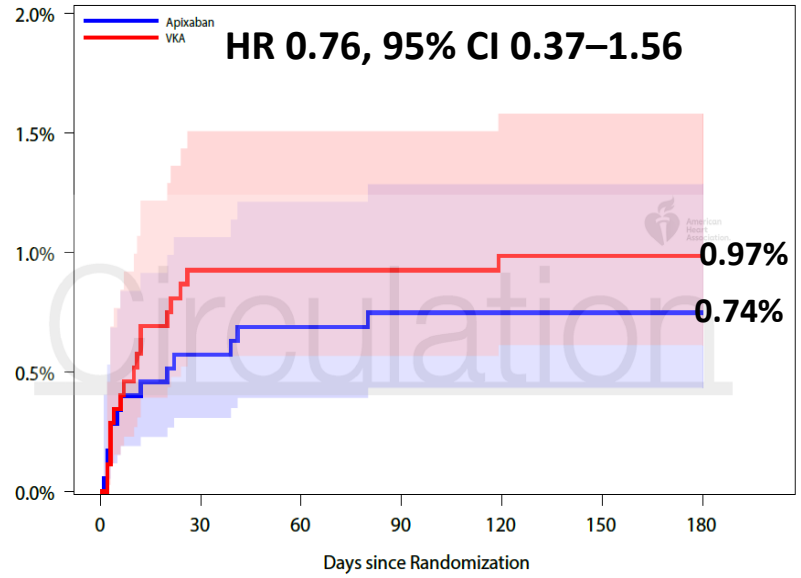


Lopes RD, et al. N Engl J Med 2019;doi:10.1056/NEJMoa1817083;
Lopes RD. Final-AUGUSTUS-Main-Results-ACC19-PRESENTATION-17-March-2019.

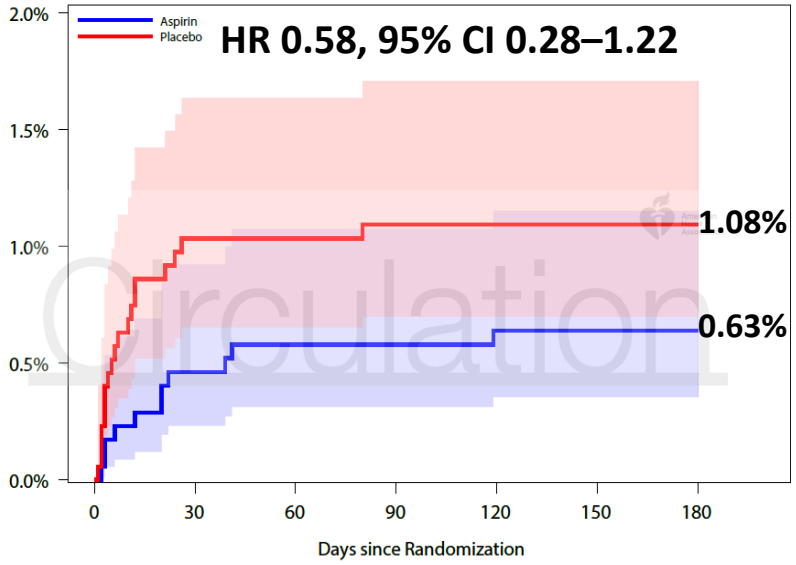
AUGUSTUS : Stent Thrombosis

Definite/Probable Stent Thrombosis

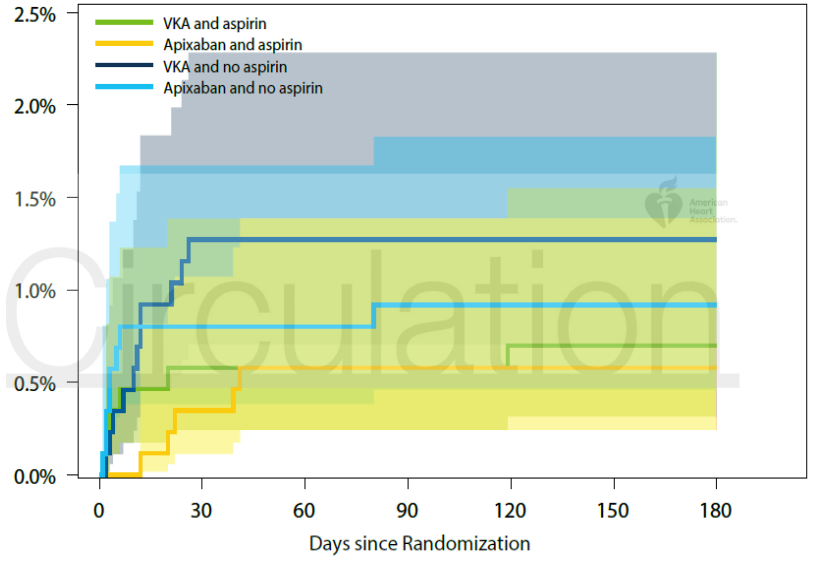
Apixaban vs VKA



Aspirin vs placebo



Intervention combination

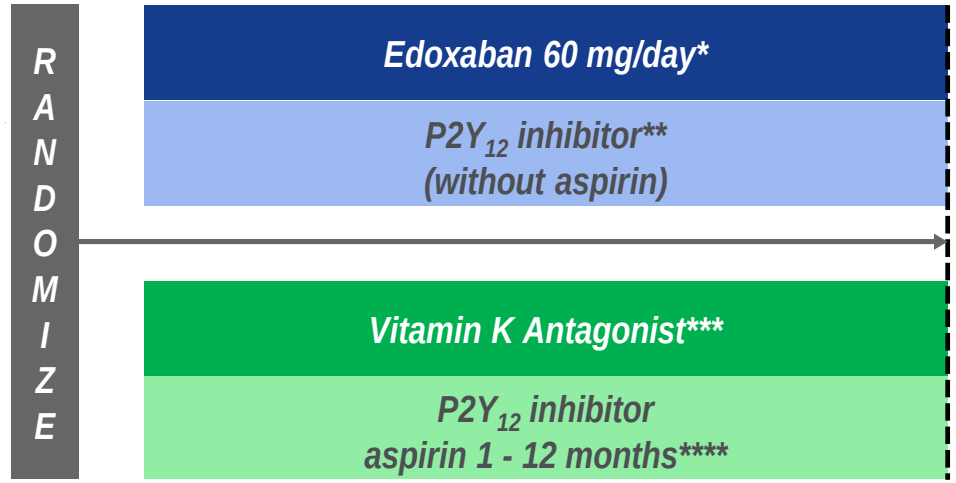


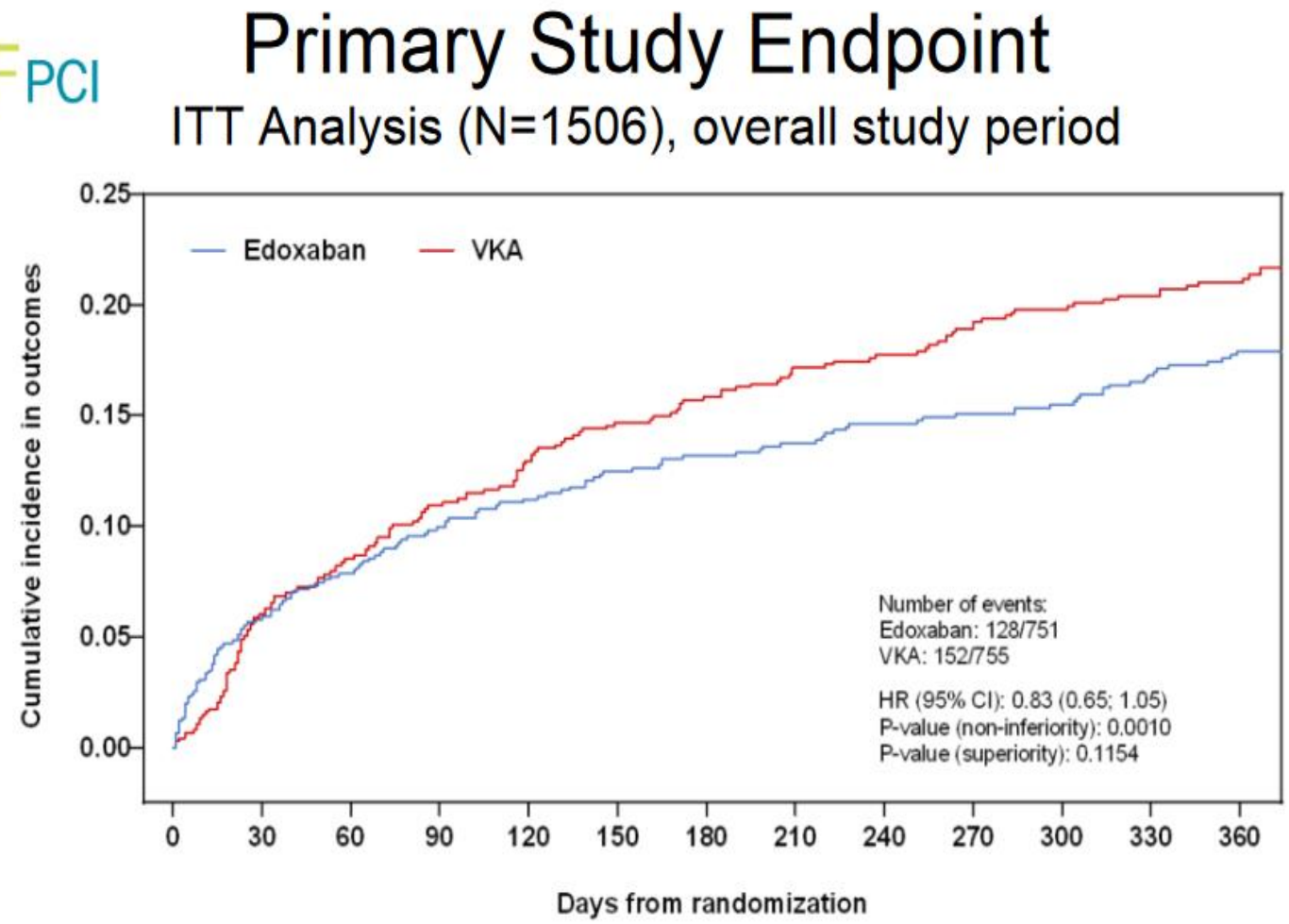
The number needed to treat (NNT) to avoid 1 stent thrombosis event for aspirin versus placebo at 6 months is 222 and the number need to harm (NNH) to cause 1 major bleeding event is 41.

Lopez R et al. 10.1161/CIRCULATIONAHA.119.044584.

Safety and efficacy of dual vs. triple antithrombotic therapy in patients with AF following PCI : **ENTRUST-AFPCI**

ENTRUST-AFPCI





Vranckx P et al. Lancet 2019.12;394:1335-1343.

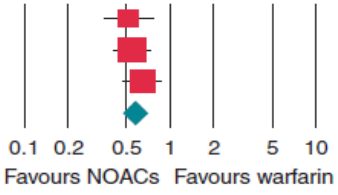
Meta-analysis of pooled data from CRT : Bleeding : NOAC better than VKA

NOAC-based regimens associated with significantly less bleeding than VKA-based regimens

(B) NOACs versus VKA

ISTH Major bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.521	0.348	0.780	–3.170	0.002
RE-DUAL PCI	0.551	0.408	0.746	–3.867	0.000
AUGUSTUS	0.644	0.472	0.878	–2.784	0.005
POOLED	0.577	0.477	0.698	–5.652	0.000

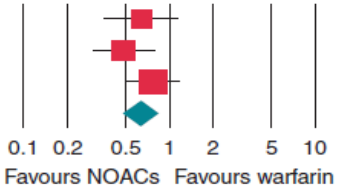


-42%

Fixed effects meta-analysis Q = 0.814, $P = 0.666$; I^2: 0%

TIMI Major bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.640	0.354	1.154	–1.484	0.138
RE-DUAL PCI	0.488	0.296	0.802	–2.831	0.005
AUGUSTUS	0.777	0.506	1.194	–1.150	0.250
POOLED	0.637	0.479	0.847	–3.099	0.002

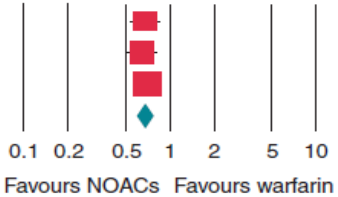


-36%

Fixed effects meta-analysis Q = 1.935, $P = 0.380$; I^2: 0%

CRNM Bleeding

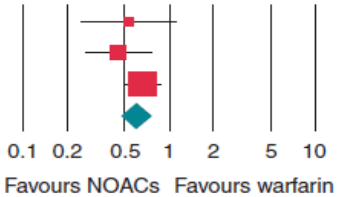
Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.671	0.525	0.858	–3.188	0.001
RE-DUAL PCI	0.645	0.519	0.802	–3.945	0.000
AUGUSTUS	0.698	0.571	0.854	–3.493	0.000
POOLED	0.673	0.593	0.763	–6.136	0.000



-33%

TIMI Minor bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.531	0.248	1.135	–1.633	0.102
RE-DUAL PCI	0.449	0.266	0.758	–2.999	0.003
AUGUSTUS	0.657	0.491	0.878	–2.841	0.004
POOLED	0.593	0.466	0.755	–4.253	0.000



-31%

Potpara TS et al. Europace. 2020 Jan 1;22(1):33-46.

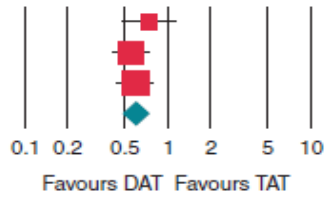
Meta-analysis of pooled data from RCT : Bleeding : DAT better than TAT

DAT-based regimens were associated with significantly less bleeding than TAT-based regimens

(A) DAT versus TAT

ISTH Major bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.735	0.468	1.155	−1.336	0.182
RE-DUAL PCI	0.551	0.408	0.746	−3.867	0.000
AUGUSTUS	0.590	0.431	0.807	−3.305	0.001
POOLED	0.598	0.491	0.727	−5.154	0.000

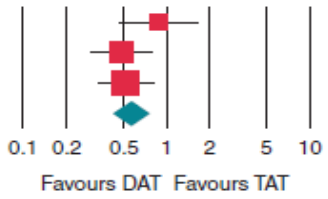


-40%

Fixed effects meta-analysis Q = 1.093, $P = 0.579$; I^2: 0%

TIMI Major bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.879	0.466	1.659	−0.397	0.692
RE-DUAL PCI	0.488	0.296	0.802	−2.831	0.005
AUGUSTUS	0.521	0.331	0.820	−2.820	0.005
POOLED	0.570	0.424	0.767	−3.715	0.000

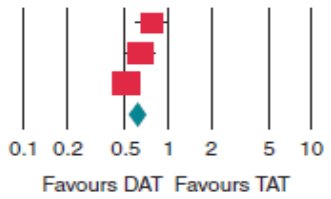


-43%

Fixed effects meta-analysis Q = 2.326, $P = 0.313$; I^2: 14%

ISTH CRNM bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.769	0.591	1001	−1.953	0.051
RE-DUAL PCI	0.645	0.519	0.802	−3.945	0.000
AUGUSTUS	0.506	0.410	0.623	−6.398	0.000
POOLED	0.613	0.537	0.698	−7.346	0.000

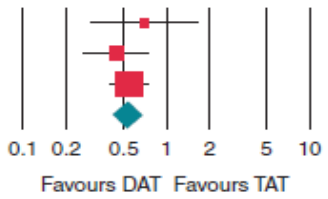


-39%

Random effects meta-analysis Q = 6.344, $P = 0.042$; I^2: 68%

TIMI Minor bleeding

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.703	0.296	1.669	−0.799	0.424
RE-DUAL PCI	0.449	0.266	0.758	−2.999	0.003
AUGUSTUS	0.549	0.408	0.739	−3.960	0.000
POOLED	0.535	0.418	0.686	−4.947	0.000



-47%

Fixed effects meta-analysis Q = 0.842, $P = 0.656$; I^2: 0%

Potpara TS et al. Europace. 2020 Jan 1;22(1):33-46.

Meta-analysis of pooled data from RCT : Myocardial infarction & stent thrombosis

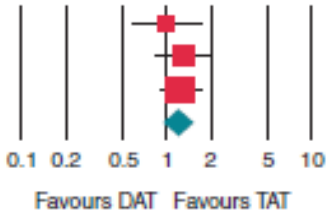
Higher rates of ST with DAT vs TAT

Similar rates of MI & ST with NOAC vs VKA

(A) DAT versus TAT

Myocardial infarction

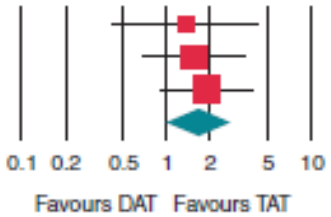
Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	1.008	0.577	1.762	0.028	0.977
RE-DUAL PCI	1.291	0.828	2.013	1.129	0.259
AUGUSTUS	1.244	0.899	1.722	1.317	0.188
POOLED	1.211	0.955	1.535	1.578	0.115



Fixed effects meta-analysis Q = 0.521, $P = 0.771$; I^2: 0%

Stent thrombosis

Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	1.370	0.435	4.318	0.538	0.591
RE-DUAL PCI	1.554	0.689	3.503	1.063	0.288
AUGUSTUS	1.923	0.925	4.001	1.750	0.080
POOLED	1.672	1.022	2.733	2.048	0.041

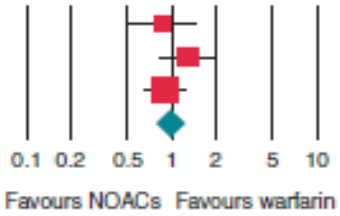


Fixed effects meta-analysis Q = 0.287, $P = 0.866$; I^2: 0%

(B) NOAC versus VKA

Myocardial infarction

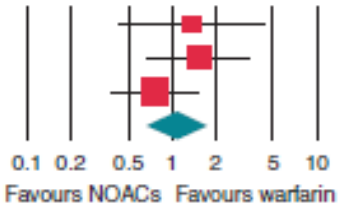
Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	0.848	0.491	1.465	−0.590	0.555
RE-DUAL PCI	1.291	0.828	2.013	1.129	0.259
AUGUSTUS	0.898	0.649	1.241	−0.654	0.513
POOLED	0.984	0.777	1.246	−0.132	0.895



Fixed effects meta-analysis Q = 2.033, $P = 0.362$; I^2: 2%

Stent thrombosis

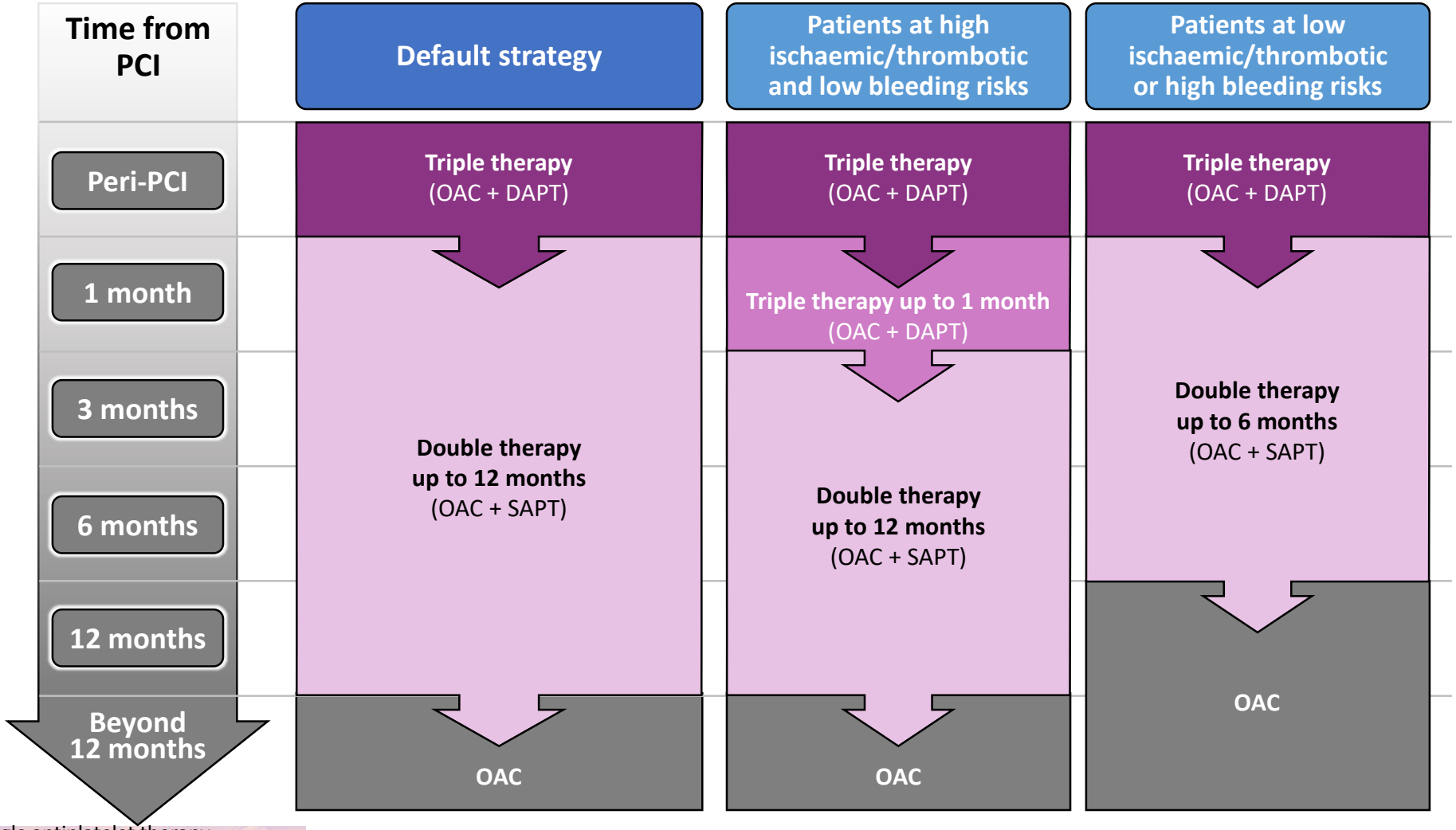
Study name	Odds ratio	Lower limit	Upper limit	Z-Value	P-Value
PIONEER AF-PCI	1.370	0.435	4.318	0.538	0.591
RE-DUAL PCI	1.554	0.689	3.503	1.063	0.288
AUGUSTUS	0.776	0.385	1.564	−0.710	0.478
POOLED	1.095	0.676	1.773	0.368	0.713



Fixed effects meta-analysis Q = 1.787, $P = 0.409$; I^2: 0%

Potpara TS et al. Europace. 2020 Jan 1;22(1):33-46.

2018 North American expert consensus document



'A **double therapy** approach (OAC + $P2Y_{12}$ inhibitor) should represent the **default strategy** for most patients…'

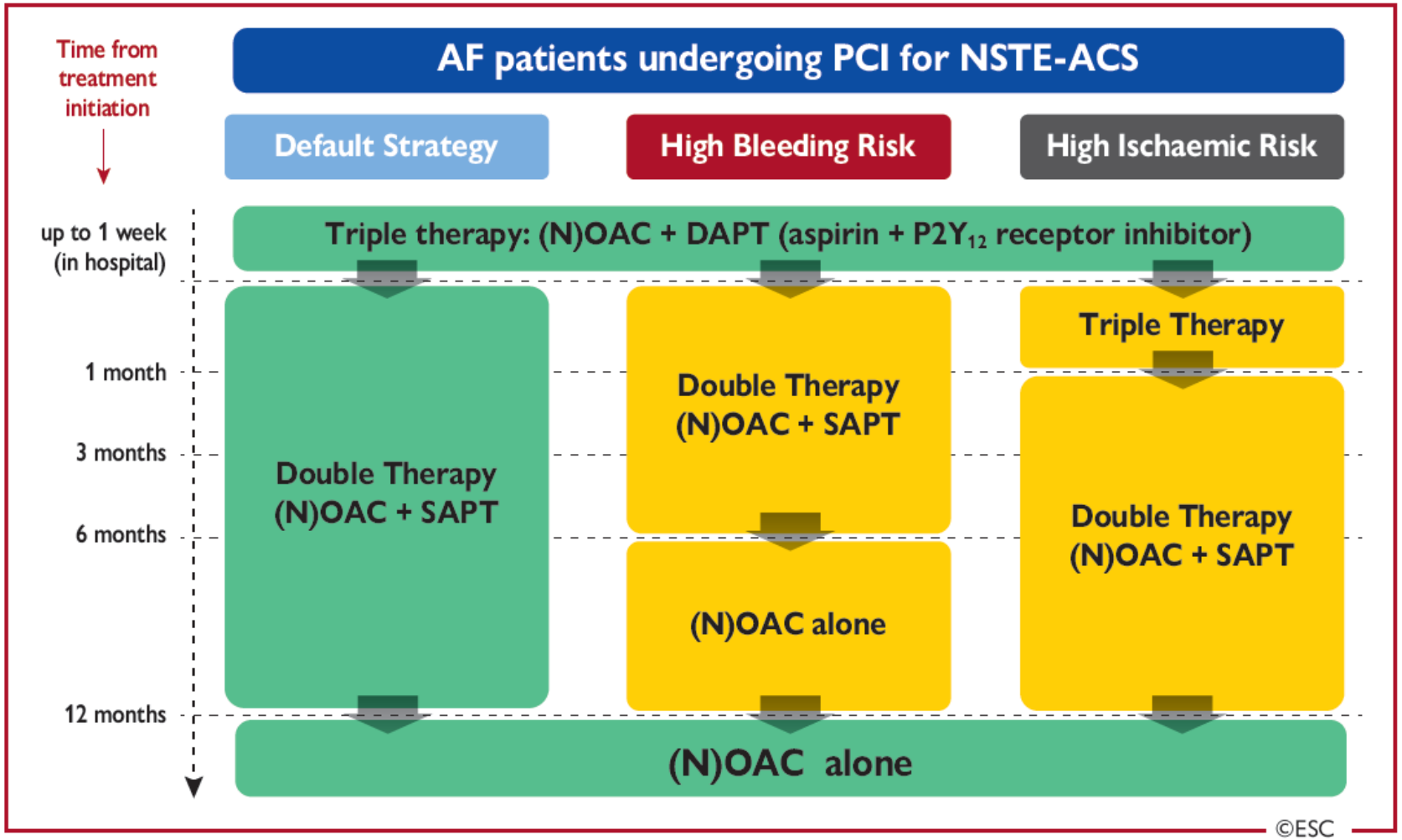
'An NOAC (rather than VKA) should generally be preferred…'

'If ticagrelor is chosen as the $P2Y_{12}$ agent, concomitant aspirin should not be given (i.e. avoid triple therapy), as was done in the RE-DUAL PCI trial'

SAPT: single antiplatelet therapy.
OAC: prefer a NOAC over VKA if no contraindications; SAPT: prefer a $P2Y_{12}$ inhibitor over aspirin.
Clopidogrel is the $P2Y_{12}$ inhibitor of choice; ticagrelor may be considered in patients at high ischaemic/thrombotic and low bleeding risks; avoid prasugrel.
Consider SAPT in addition to OAC after >12 months only in select patients at high ischaemic/thrombotic and low bleeding risks.

Angiolillo, et al. Circulation 2018;138:527–36.

2020 ESC Guidelines : antithrombotic therapy in NSTE-ACS pts with AF undergoing PCI or medical management

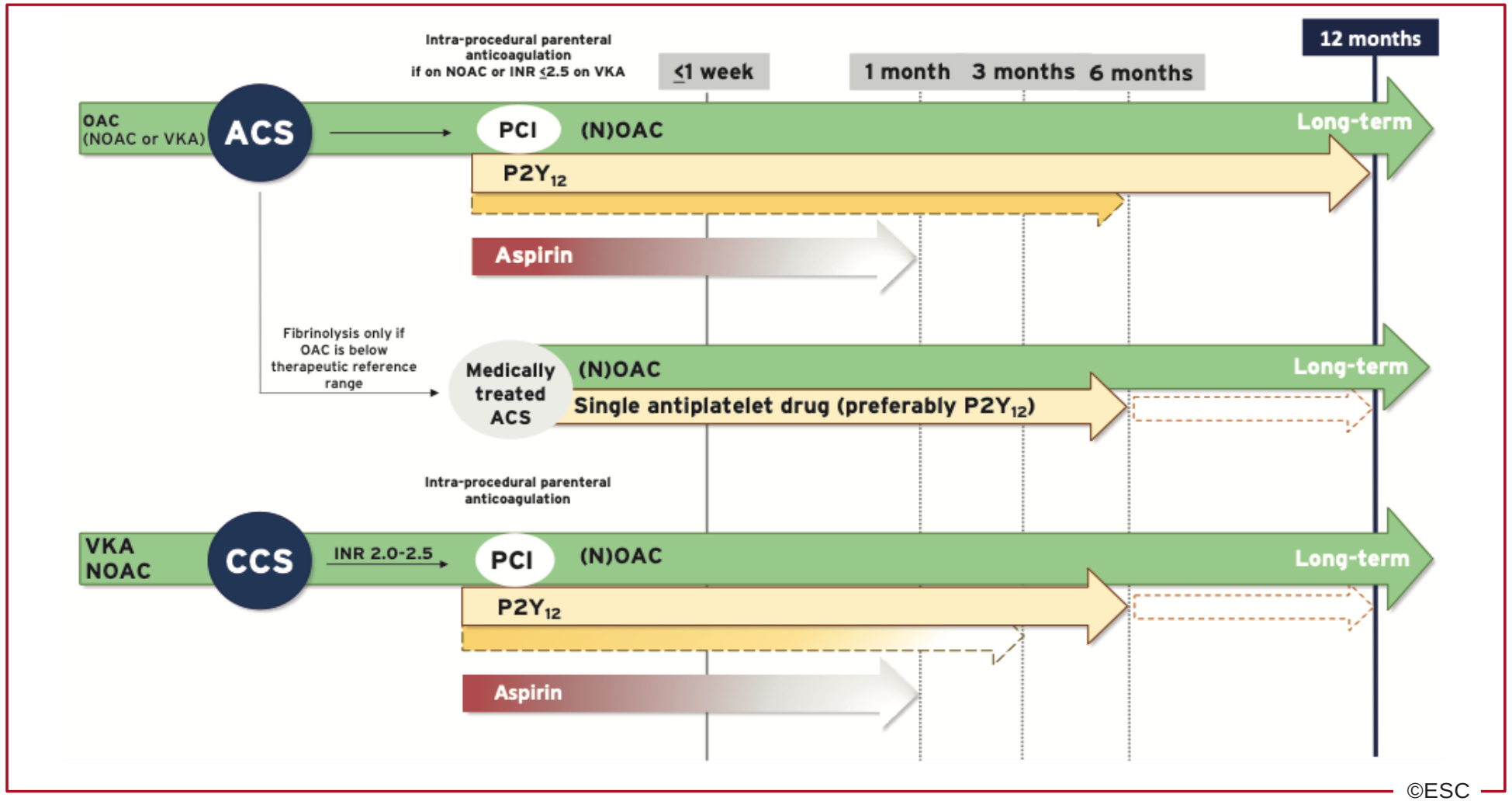


Green (Class I)
yellow (Class IIa)

2020 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation (European Heart Journal 2020 - doi/10.1093/eurheartj/ehaa575)

2020 ESC Guidelines : post-procedural management of pts with AF and ACS/PCI

ESC European Society of Cardiology



2020 ESC Guidelines for the diagnosis and management of atrial fibrillation (European Heart Journal 2020-doi/10.1093/eurheartj/ehaa612)

2020 ESC Guidelines : post-procedural management of pts with AF and ACS/PCI

ESC European Society of Cardiology

THROMBOTIC RISK FACTORS

- Diabetes mellitus requiring therapy
- Prior ACS/recurrent myocardial infarction
- Multivessel CAD
- Concomitant PAD
- Premature CAD (occurring at age of <45 y) or accelerated CAD (new lesion within 2 years)
- CKD (eGFR <60 mL/min)
- Clinical presentation (ACS)
- Multivessel stenting
- Complex revascularisation (left main stenting, bifurcation lesion stenting, chronic total occlusion intervention, last patent vessel stenting)
- Prior stent thrombosis on antiplatelet treatment
- Procedural factors (stent expansion, residual dissection, stent length, etc.)

BLEEDING RISK FACTORS

- Hypertension
- Abnormal renal or liver function
- Stroke or ICH history
- Bleeding history or bleeding diathesis (e.g., anaemia with haemoglobin <110 g/L)
- Labile INR (if on VKA)
- Elderly (>65 years)
- Drugs (concomitant OAC and antiplatelet therapy, NSAIDs), excessive alcohol consumption

STRATEGIES TO REDUCE BLEEDING ASSOCIATED WITH PCI

- Radial artery access
- PPIs in patients taking DAPT who are at increased risk of bleeding (e.g., the elderly, dyspepsia, gastro-oesophageal reflux disease, Helicobacter pylori infection, chronic alcohol use)
- Non–administration of unfractionated heparin in patients on VKA with INR >2.5
- Pre-treatment with aspirin only, add a $P2Y_{12}$ inhibitor when coronary anatomy is known or if STEMI
- GP IIb/IIIa inhibitors only for bailout or periprocedural complications
- Shorter duration of combined antithrombotic therapy

2020 ESC Guidelines for the diagnosis and management of atrial fibrillation (European Heart Journal 2020-doi/10.1093/eurheartj/ehaa612)

Recommendations for patients with AF and an ACS, PCI, or CCS (1)

ESC European Society of Cardiology

Recommendations	Class	Level
General recommendations for patients with AF and an indication for concomitant antiplatelet therapy		
In AF patients eligible for NOACs, it is recommended to use a NOAC[a] in preference to a VKA in combination with antiplatelet therapy.	I	A
In patients at high bleeding risk (HAS-BLED ≥3), rivaroxaban 15 mg o.d. should be considered in preference to rivaroxaban 20 mg o.d. for the duration of concomitant single or DAPT, to mitigate bleeding risk.	IIa	B
In patients at high bleeding risk (HAS-BLED ≥3), dabigatran 110 mg b.i.d. should be considered in preference to dabigatran 150 mg b.i.d. for the duration of concomitant single or DAPT, to mitigate bleeding risk.	IIa	B
In AF patients with an indication for a VKA in combination with antiplatelet therapy, the VKA dosing should be carefully regulated with a target INR of 2.0–2.5 and TTR >70%.	IIa	B

(European Heart Journal 2020-doi/10.1093/eurheartj/ehaa612)

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

ESC European Society of Cardiology

Recommendations	Class	Level
Antithrombotic therapy in post-PCI patients with AF or another indication for an OAC		
Dual therapy with an OAC and either ticagrelor or prasugrel may be considered as an alternative to triple therapy with an OAC, aspirin, and clopidogrel in patients with a moderate or high risk of stent thrombosis,[a] irrespective of the type of stent used.	IIb	C
The use of ticagrelor or prasugrel is not recommended as part of triple antithrombotic therapy with aspirin and an OAC.	III	C

[a] Risk of stent thrombosis encompasses (i) the risk of thrombosis occurring and (ii) the risk of death should stent thrombosis occur, both of which relate to anatomical, procedural, and clinical characteristics. Risk factors for CCS patients include stenting of left main stem, proximal LAD, or last remaining patent artery; suboptimal stent deployment; stent length >60 mm; diabetes mellitus; CKD; bifurcation with two stents implanted; treatment of chronic total occlusion; and previous stent thrombosis on adequate antithrombotic therapy.

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

Conclusion : AF and acute coronary syndrome

- Which anticoagulant treatment: In most patients, NOACs should be preferred over VKA unless contraindicated
- Which $P2Y_{12}$ inhibitor : Clopidogrel is the first-line choice;
- When and for Whom:
  - **Dual**-therapy (OAC plus P2Y12 inhibitor) immediately or early after hospital discharge should be considered for most patients.
  - **Triple**-therapy (extended use of aspirin beyond hospital discharge) should be considered only for patients at high ischemic/thrombotic* and low bleeding risks. Duration should be limited (e.g. 1 month)

*High atherothrombotic risk as assessed by SYNTAX score (PCI), Grace score > 140 (ACS), stenting of left main or proximal LAD; proximal bifurcation, recurrent ACS, stent thrombosis….
*Bleeding risk as assessed by HAS-BLED score, BARC Consensus