

Akutní koronární syndrom :
ANTITROMBOTICKÁ LÉČBA

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Antitrombotická léčba ACS



Antitrombotická léčba ACS



ESC GUIDELINES

Doporučení pro... | Guidelines

Doporučení ESC pro léčbu akutních koronárních syndromů 2023.

Byrne RA, Rossello X, Coughlan JJ, Barbato E, Berry C, Chieffo A, Claeys MJ, Dan GA, Dweck MR, Galbraith M, Gilard M, Hinterbuchner L, Jankowska EA, Jüni P, Kimura T, Kunadian V, Leosdottir M, Lorusso R, Pedretti RFE, Rigopoulos AG, Rubini Gimenez M, Thiele H, Vranckx P, Wassmann S, Wenger NK, Ibanez B; ESC Scientific Document Group.

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(2023 ESC Guidelines for the management of acute coronary syndromes.

Byrne RA, Rossello X, Coughlan JJ, Barbato E, Berry C, Chieffo A, Claeys MJ, Dan GA, Dweck MR, Galbraith M, Gilard M, Hinterbuchner L, Jankowska EA, Jüni P, Kimura T, Kunadian V, Leosdottir M, Lorusso R, Pedretti RFE, Rigopoulos AG, Rubini Gimenez M, Thiele H, Vranckx P, Wassmann S, Wenger NK, Ibanez B; ESC Scientific Document Group.

Translation of the shortened document prepared by the Czech Interventional Cardiology Association, the Czech Acute Cardiac Care Association of the Czech Society of Cardiology and the Czech Society of Cardiovascular Surgery of ČLS JEP)

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Antitrombotická léčba ACS : současná výbava

Table 6 Dose regimen of antiplatelet and anticoagulant drugs in acute coronary syndrome patients

I. Antiplatelet drugs	
Aspirin	LD of 150–300 mg orally or 75–250 mg i.v. if oral ingestion is not possible, followed by oral MD of 75–100 mg o.d.; no specific dose adjustment in CKD patients.
P2Y ₁₂ receptor inhibitors (oral or i.v.)	
Clopidogrel	LD of 300–600 mg orally, followed by an MD of 75 mg o.d.; no specific dose adjustment in CKD patients. Fibrinolysis: at the time of fibrinolysis an initial dose of 300 mg (75 mg for patients older than 75 years of age).
Prasugrel	LD of 60 mg orally, followed by an MD of 10 mg o.d. In patients with body weight <60 kg, an MD of 5 mg o.d. is recommended. In patients aged ≥75 years, prasugrel should be used with caution, but a MD of 5 mg o.d. should be used if treatment is deemed necessary. No specific dose adjustment in CKD patients. Prior stroke is a contraindication for prasugrel.
Ticagrelor	LD of 180 mg orally, followed by an MD of 90 mg b.i.d.; no specific dose adjustment in CKD patients.
Cangrelor	Bolus of 30 mcg/kg i.v. followed by 4 mcg/kg/min infusion for at least 2 h or the duration of the procedure (whichever is longer). In the transition from cangrelor to a thienopyridine, the thienopyridine should be administered immediately after discontinuation of cangrelor with an LD (clopidogrel 600 mg or prasugrel 60 mg); to avoid a potential DDI, prasugrel may also be administered 30 min before the cangrelor infusion is stopped. Ticagrelor (LD 180 mg) should be administered at the time of PCI to minimize the potential gap in platelet inhibition during the transition phase.
GP IIb/IIIa receptor inhibitors (i.v.)	
Eptifibatid	Double bolus of 180 mcg/kg i.v. (given at a 10-min interval) followed by an infusion of 2.0 mcg/kg/min for up to 18 h. For CrCl 30–50 mL/min: first LD, 180 mcg/kg i.v. bolus (max 22.6 mg); maintenance infusion, 1 mcg/kg/min (max 7.5 mg/h). Second LD (if PCI), 180 mcg/kg i.v. bolus (max 22.6 mg) should be administered 10 min after the first bolus. Contraindicated in patients with end-stage renal disease and with prior ICH, ischaemic stroke within 30 days, fibrinolysis, or platelet count <100 000/mm ³ .
Tirofiban	Bolus of 25 mcg/kg i.v. over 3 min, followed by an infusion of 0.15 mcg/kg/min for up to 18 h. For CrCl ≤60 mL/min: LD, 25 mcg/kg i.v. over 5 min followed by a maintenance infusion of 0.075 mcg/kg/min continued for up to 18 h. Contraindicated in patients with prior ICH, ischaemic stroke within 30 days, fibrinolysis, or platelet count <100 000/mm ³ .
II. Anticoagulant drugs	
UFH	Initial treatment: i.v. bolus 70–100 U/kg followed by i.v. infusion titrated to achieve an aPTT of 60–80 s. During PCI: 70–100 U/kg i.v. bolus or according to ACT in case of UFH pre-treatment.
Enoxaparin	Initial treatment: for treatment of ACS 1 mg/kg b.i.d. subcutaneously for a minimum of 2 days and continued until clinical stabilization. In patients whose CrCl is below 30 mL per minute (by Cockcroft–Gault equation), the enoxaparin dosage should be reduced to 1 mg per kg o.d. During PCI: for patients managed with PCI, if the last dose of enoxaparin was given less than 8 h before balloon inflation, no additional dosing is needed. If the last s.c. administration was given more than 8 h before balloon inflation, an i.v. bolus of 0.3 mg/kg enoxaparin sodium should be administered.
Bivalirudin	During PPCI: 0.75 mg/kg i.v. bolus followed by i.v. infusion of 1.75 mg/kg/h for 4 h after the procedure. In patients whose CrCl is below 30 mL/min (by Cockcroft–Gault equation), maintenance infusion should be reduced to 1 mg/kg/h.
Fondaparinux	Initial treatment: 2.5 mg/d subcutaneously. During PCI: A single bolus of UFH is recommended. Avoid if CrCl <20 mL/min.

Antitrombotická léčba STEMI : akutní fáze

1. kyselina acetylsalicylová (ASA)

nasycovací dávka (LD) : 400 mg p.o. nebo lysin salicylát i.v.

2. inhibitor P2Y12 receptoru (při SKG!)

LD (p.o.) : prasugrel 60 mg / 180 mg ticagrelor / 600 mg clopidogrel

I.V. CANGRELOR

3. nefrakcionovaný heparin (UFH)

Dávka při transportu spíše nižší, pro PCI podle ACT (250 – 300 s)

Antitrombotická léčba **N**STEMI : akutní fáze, SKG do 24 hodin

1. kyselina acetylsalicylová (ASA)

nasyčovací dávka (LD) : 400 mg p.o. nebo lysin salicylát i.v.

2. inhibitor P2Y₁₂ receptoru

LD (p.o.) až po provedení koronarografie

3. nefrakcionovaný heparin (UFH)

UFH 70-100 IU/kg i.v. a poté dle aPTT 60-80 s

LMWH (enoxaparin)

Antitrombotická léčba **NSTEMI** : akutní fáze, SKG \geq 24 hodin

1. kyselina acetylsalicylová (ASA)

nasycovací dávka (LD) : 400 mg p.o. nebo lysin salicylát i.v.

2. inhibitor P2Y₁₂ receptoru

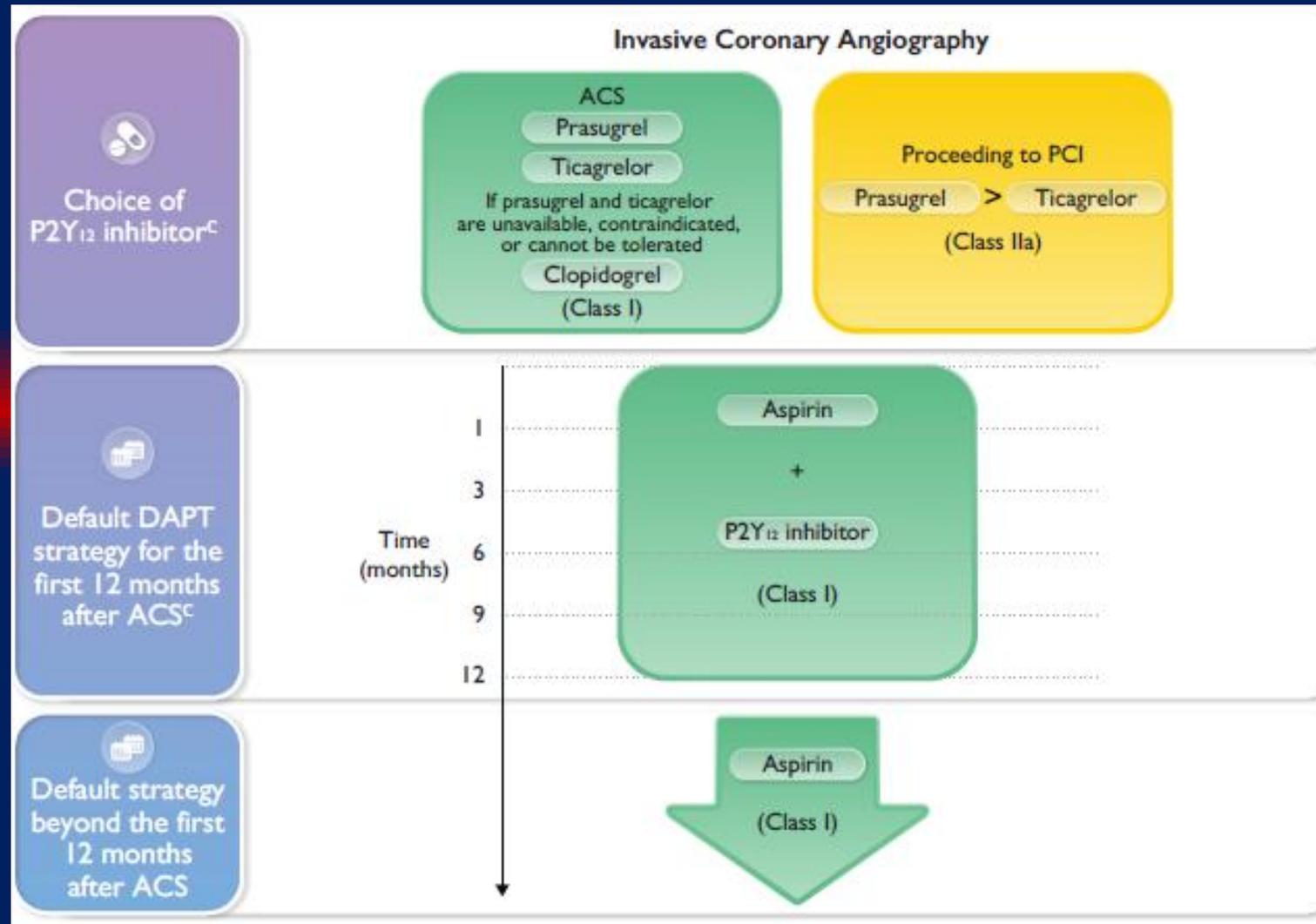
LD (p.o.) ticagrelor nebo clopidogrel

3. nefrakcionovaný heparin (UFH)

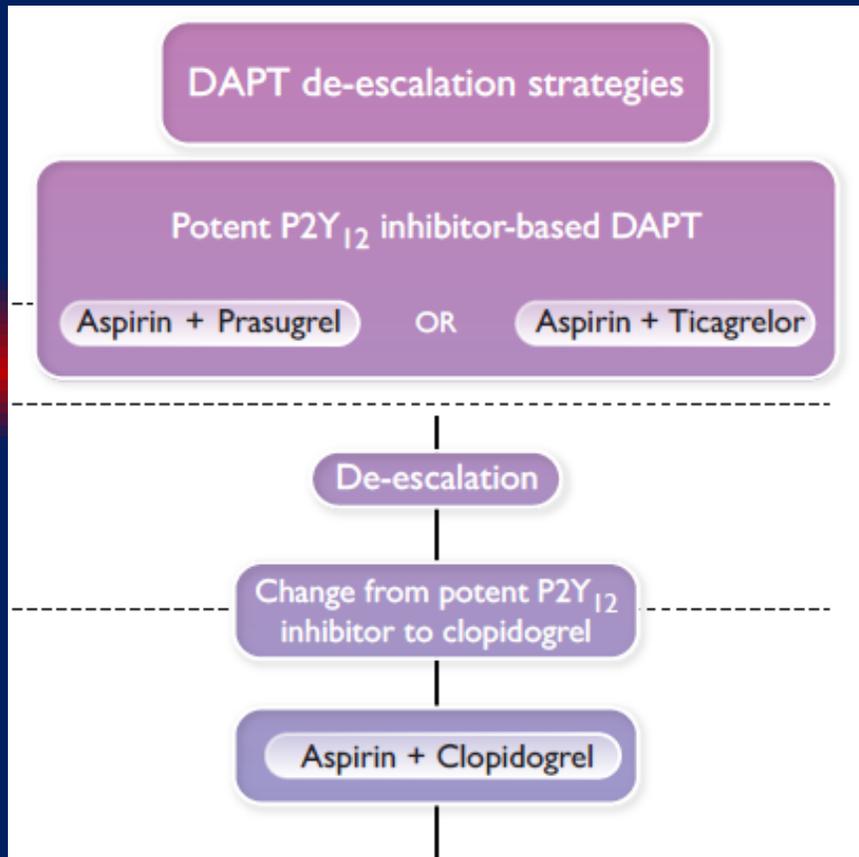
fondaparinux

LMWH (enoxaparin)

Antitrombotická léčba po akutním koronárním syndromu



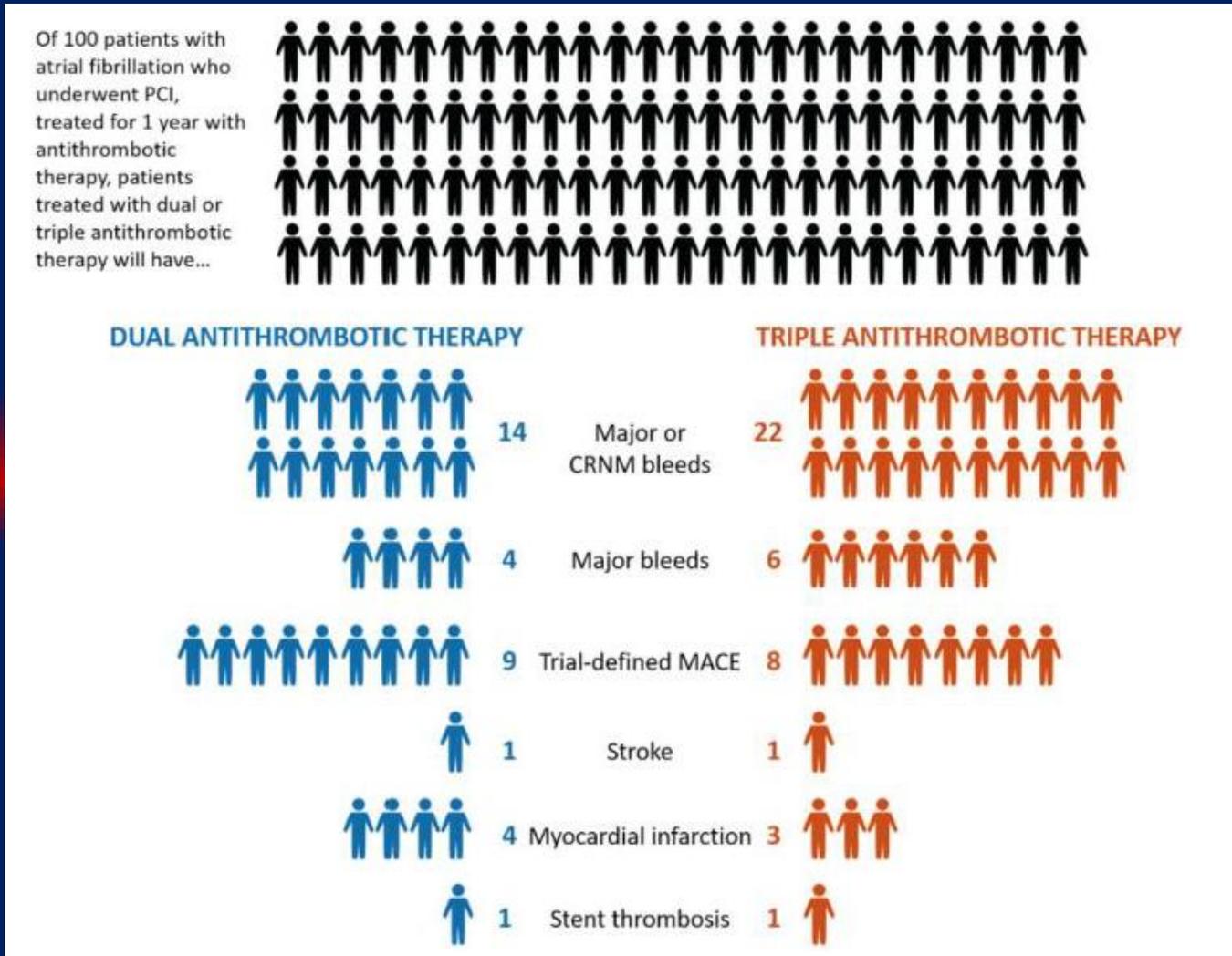
Antitrombotická léčba po ACS : deescalace na clopidogrel



- Prokázána možnost snížení krvácivých komplikací
 - Není prokázána srovnatelná bezpečnost z hlediska ischemických komplikací, zvláště u rizikových nemocných

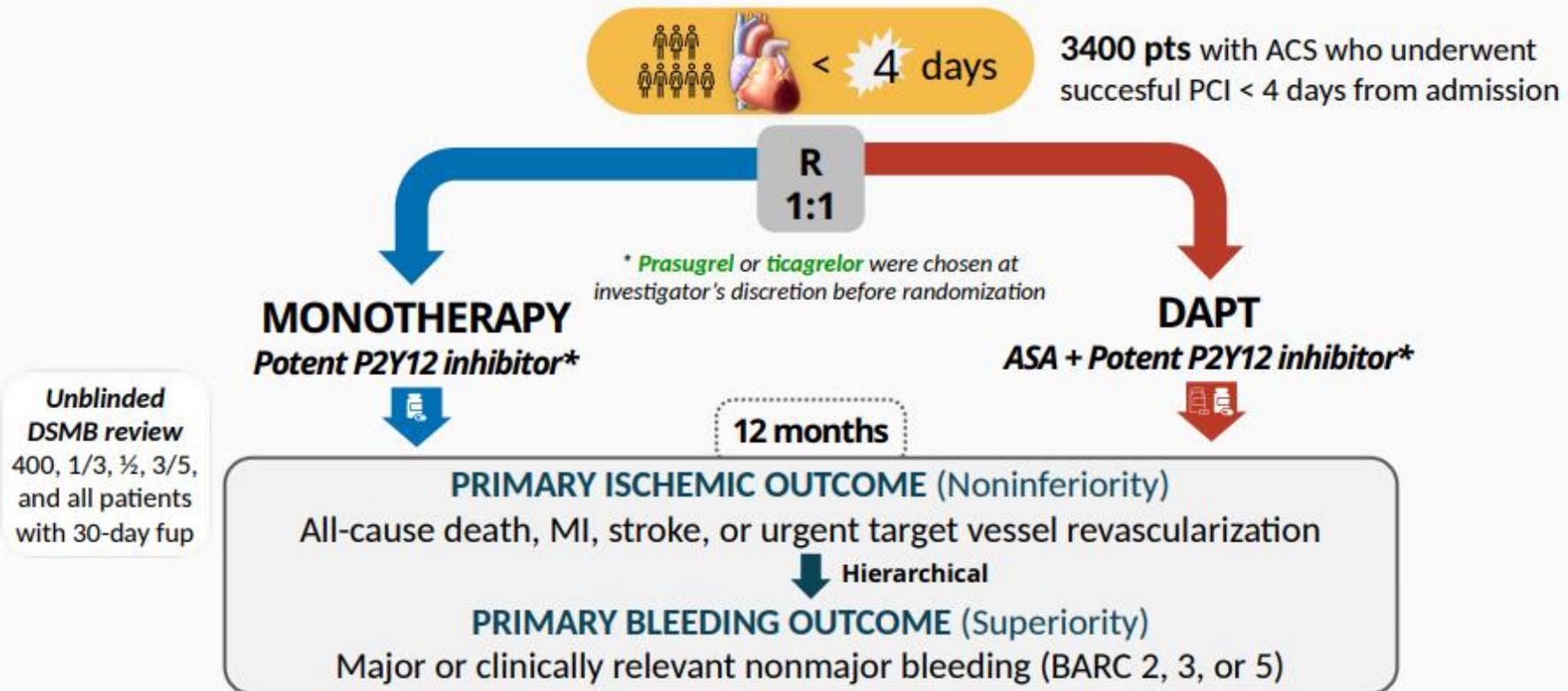
**Lze zvážit po 30 dnech od ACS
pro snížení rizika krvácení**

Antitrombotická léčba ACS : pacient s indikací k OAC

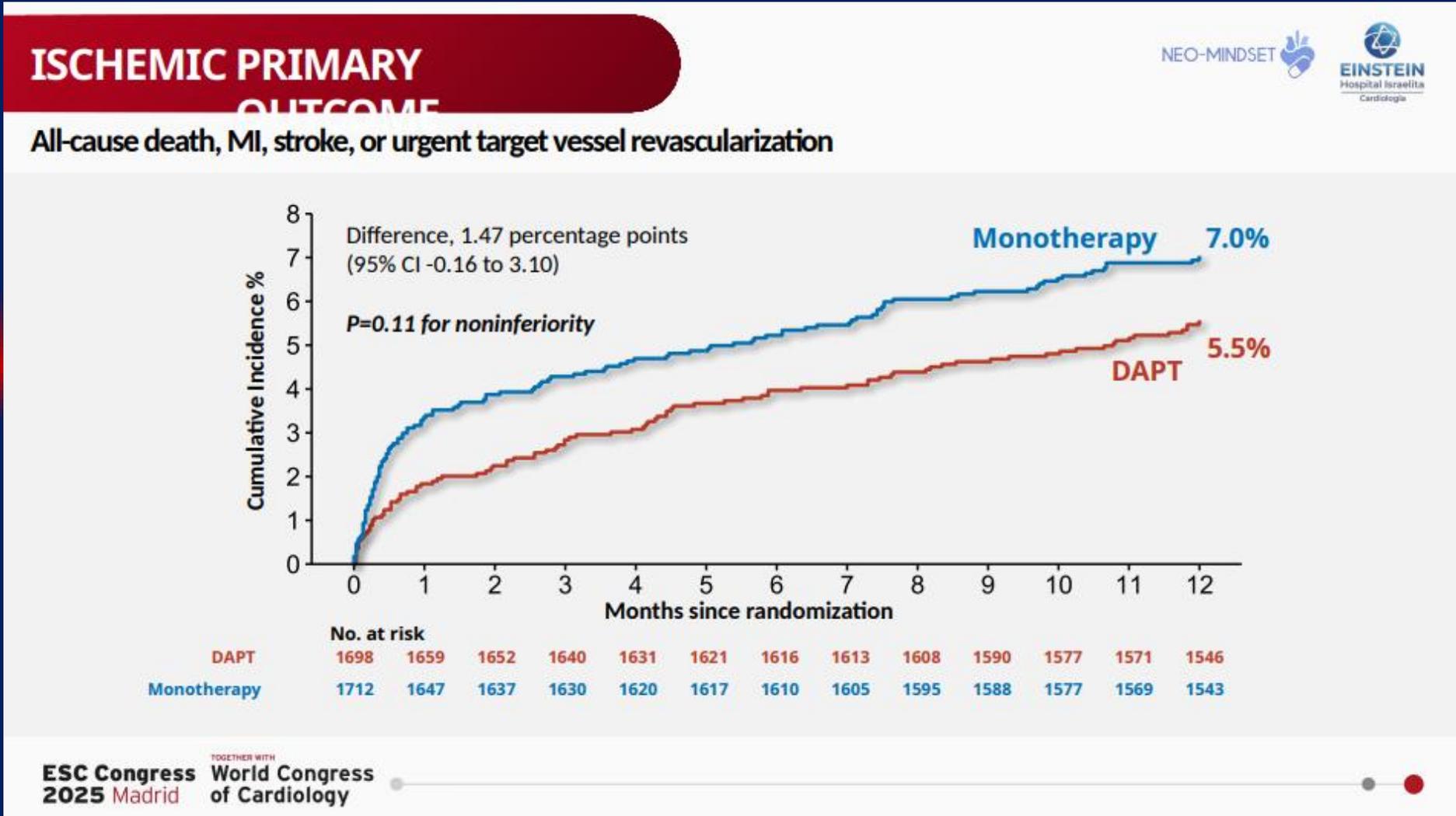


NEO MINDSET: časné vysazení ASA po PCI pro ACS ?

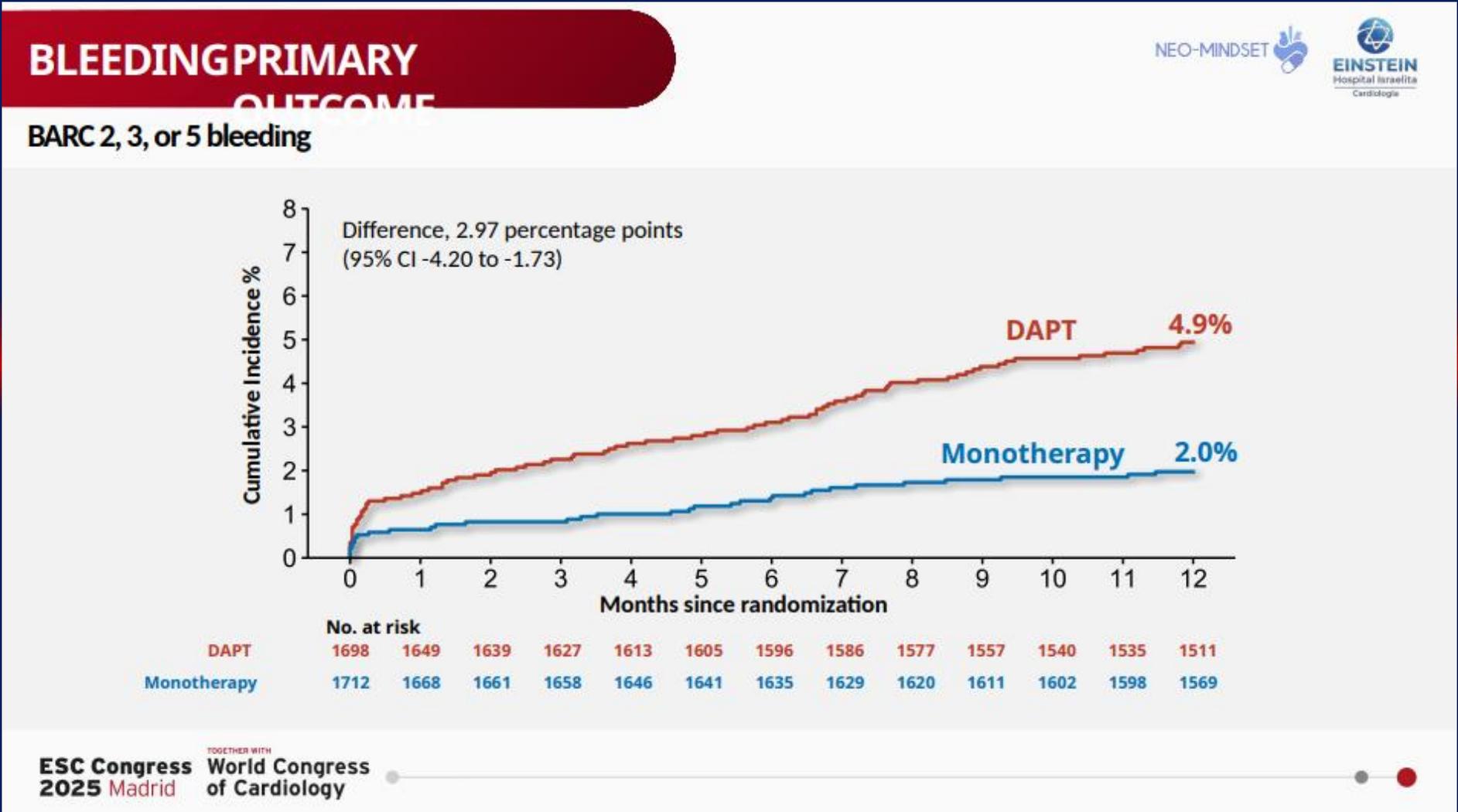
STUDY DESIGN



NEO MINDSET: časné vysazení ASA po PCI pro ACS ?

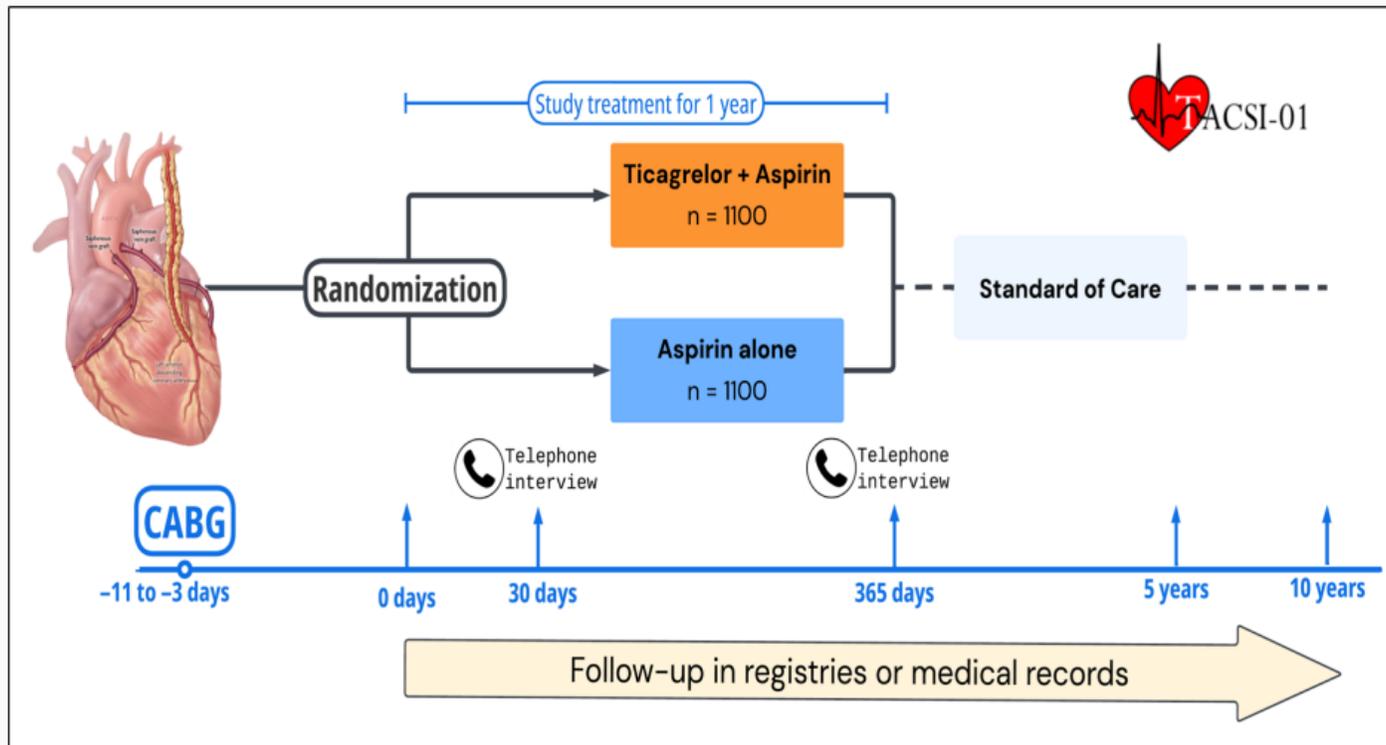


NEO MINDSET: časné vysazení ASA po PCI pro ACS ?



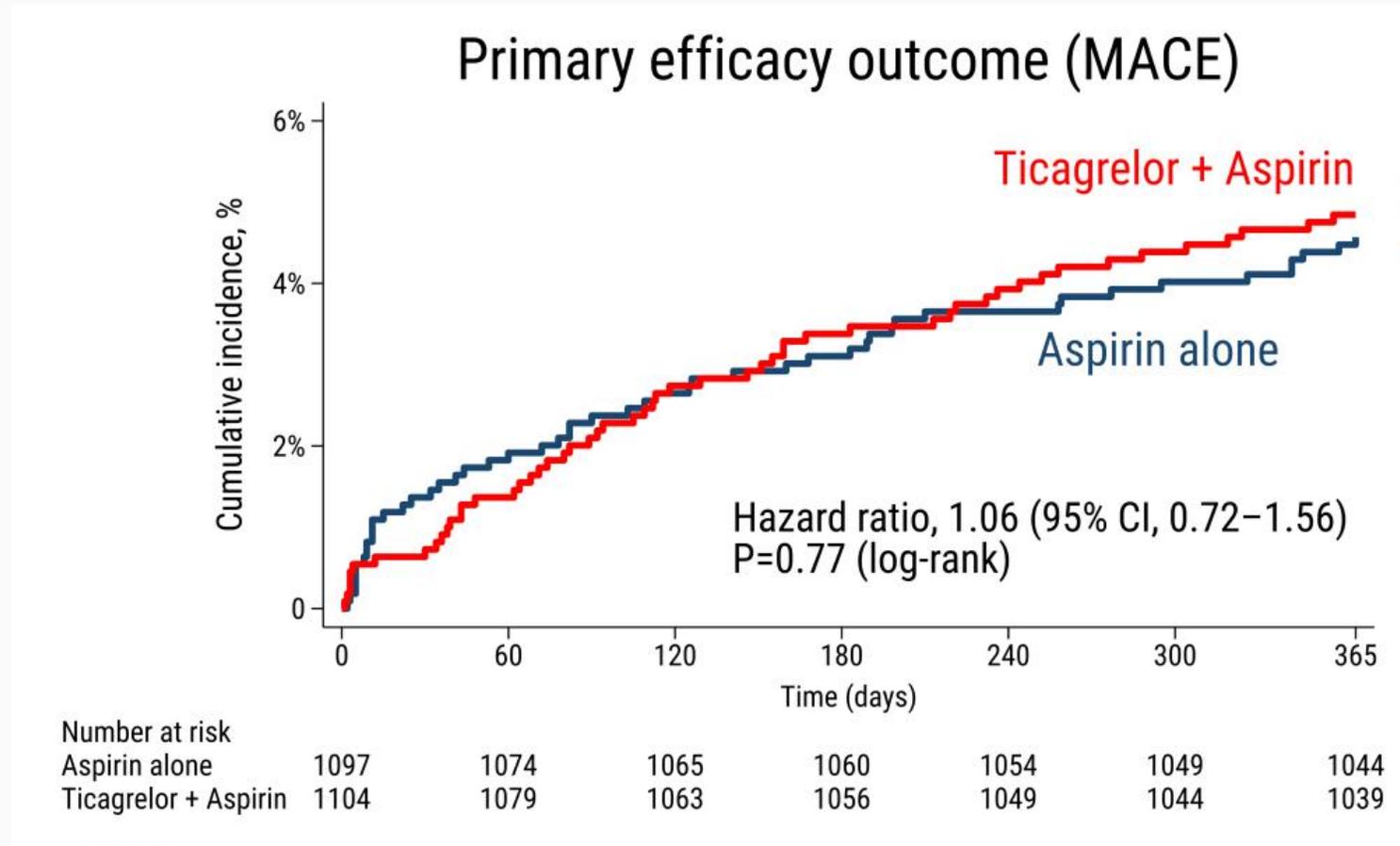
TACSI : DAPT po CABG pro akutní koronární syndrom ?

Study design

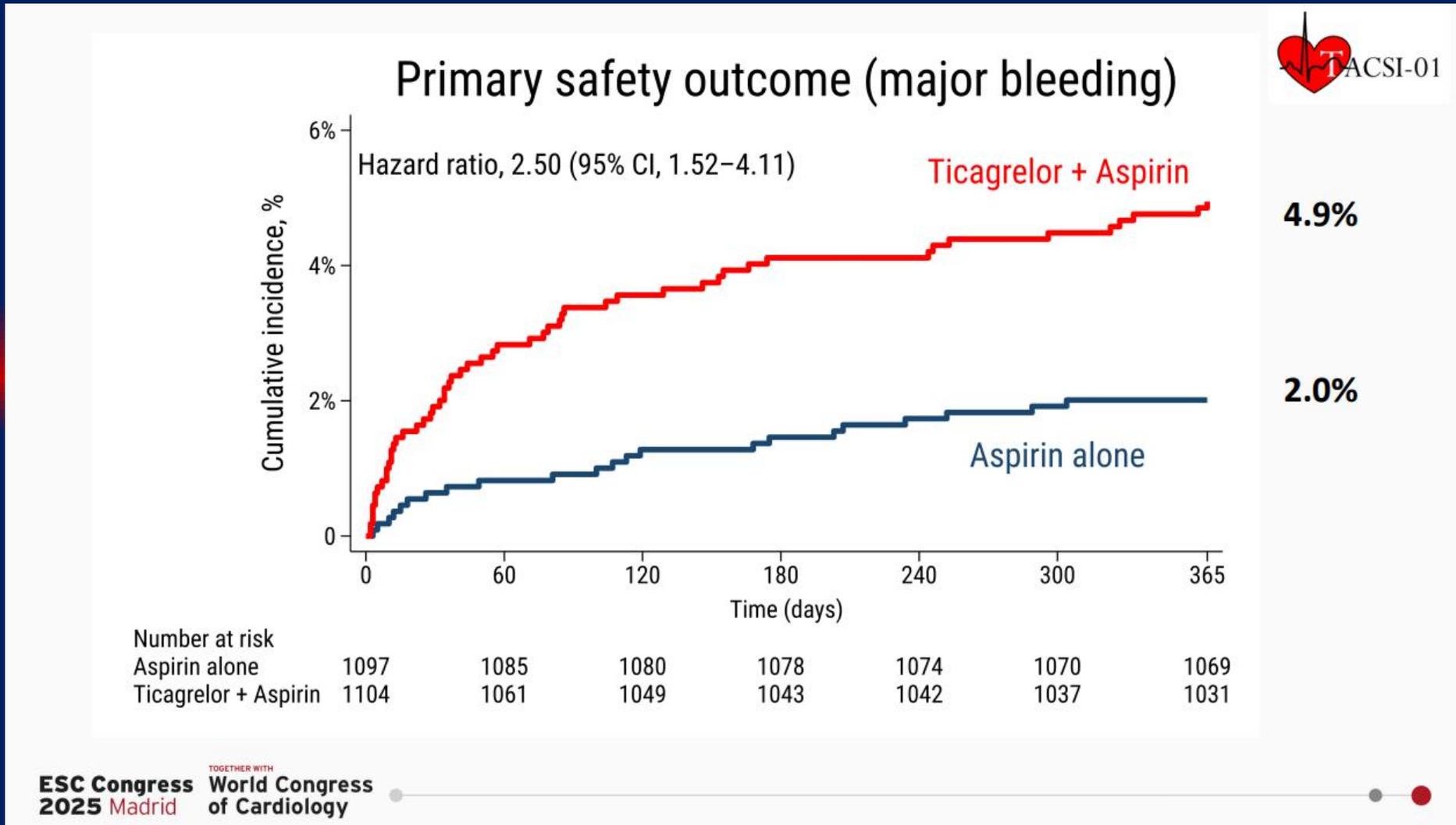


12 months open label treatment with ticagrelor 90 mg x 2 + aspirin 75-100 mg x 1) or Aspirin only (75-160 mg x 1)

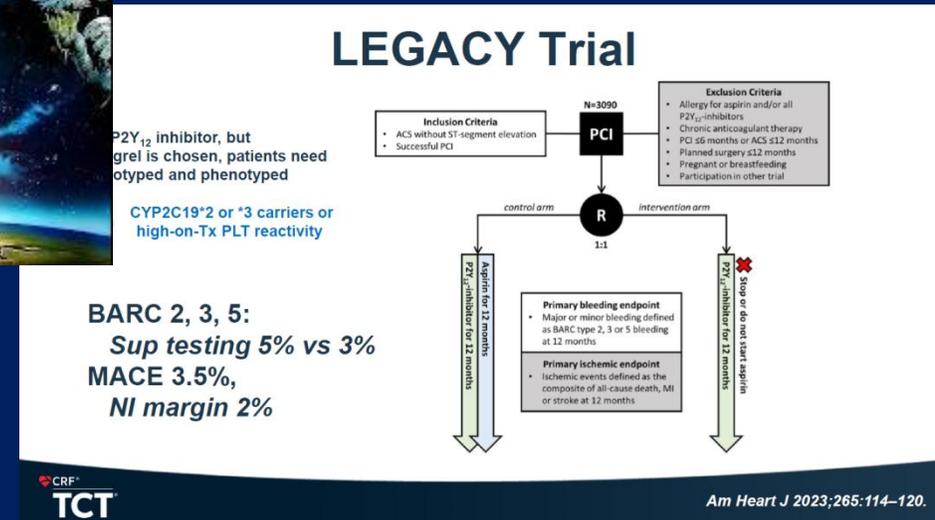
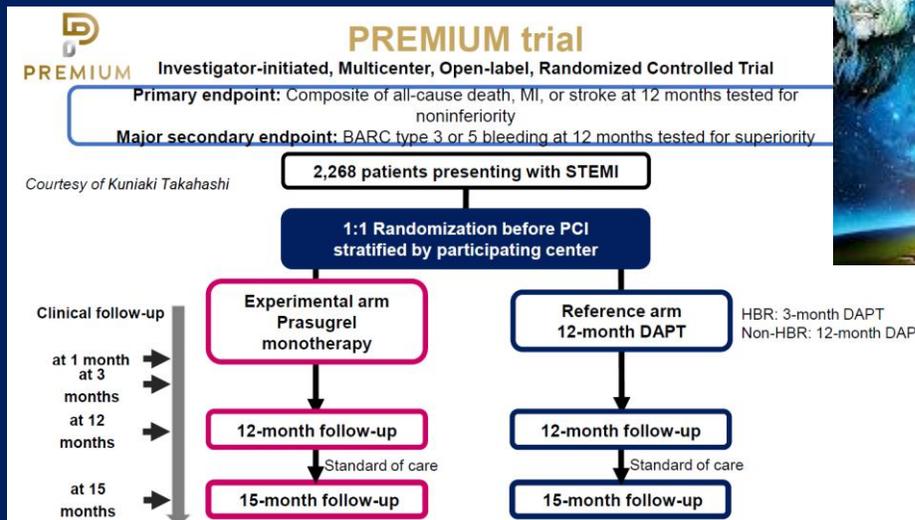
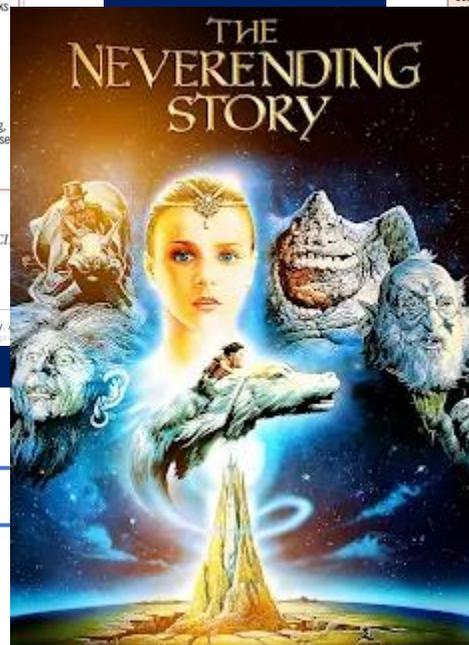
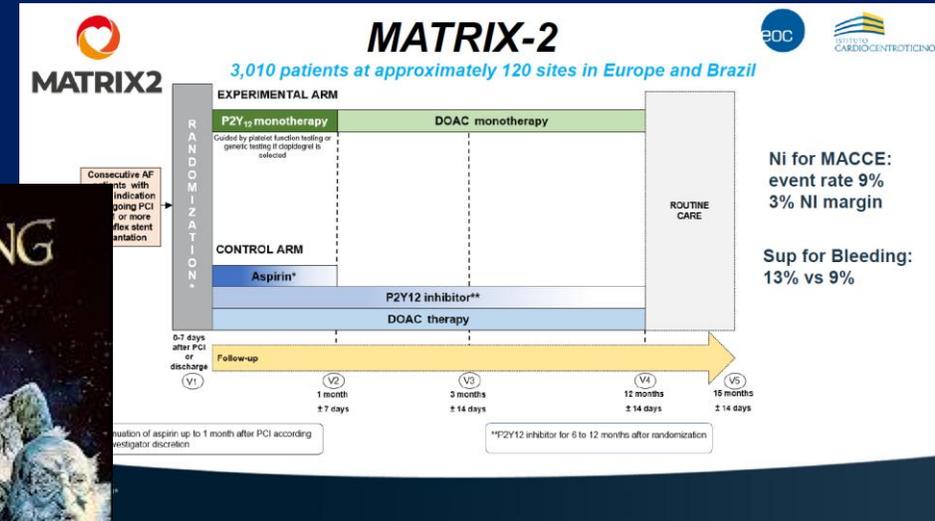
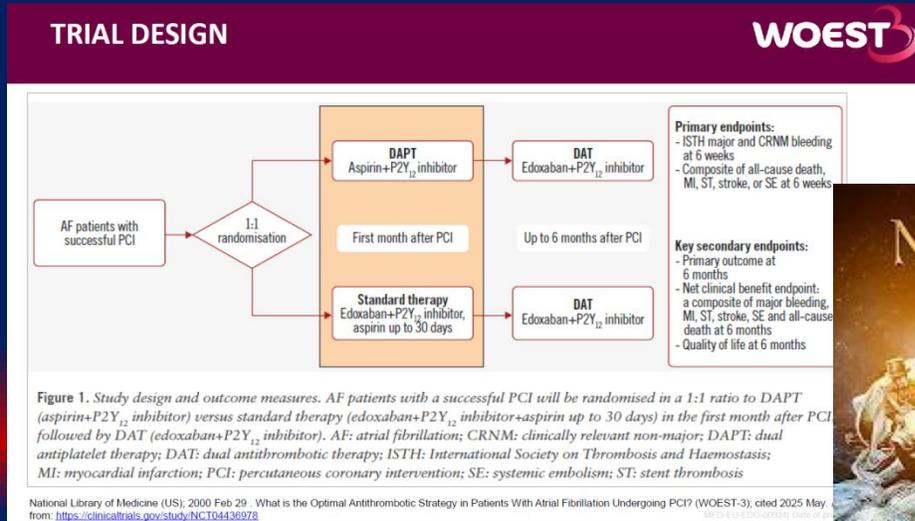
TACSI : DAPT po CABG pro akutní koronární syndrom ?



TACSI : DAPT po CABG pro akutní koronární syndrom ?



Antitrombotická léčba ACS : ukončený vývoj ?



Antitrombotická léčba po ACS : závěr

