AOMI et FA:
Quelle Stratégie Anti-Thrombotique?

Pr. Victor Aboyans

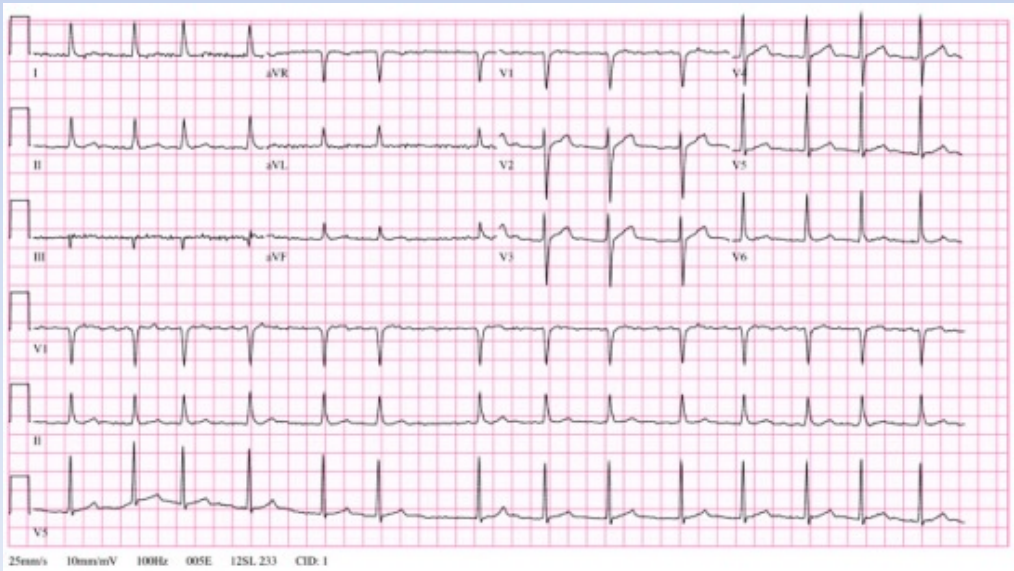
Service de Cardiologie

CHU Dupuytren,

Limoges, France

Cas Clinique

- Homme 75 ans, DNID, ex-fumeur, HTA.
- ATCD **pontage aorto-iliaque** il y a 5 ans. Asymptomatique.
- Trt: Metformine, Ramipril, Pravastatine, **Aspirine 75mg**.
- Consultation: épisodes de palpitation.
- Clin: BDC irréguliers sans souffle. Pas d'IC.
- ECG: **Fibrillation atriale**, 90-100 bpm.



- ETT: FEVG 58%. Pas de valvulopathie.
- Bio: eGFR = 65 ml/mn. TSH: N.

Cas Clinique

Quelle serait votre stratégie antithrombotique?

A- AVK + Aspirine

B- NACO + Aspirine

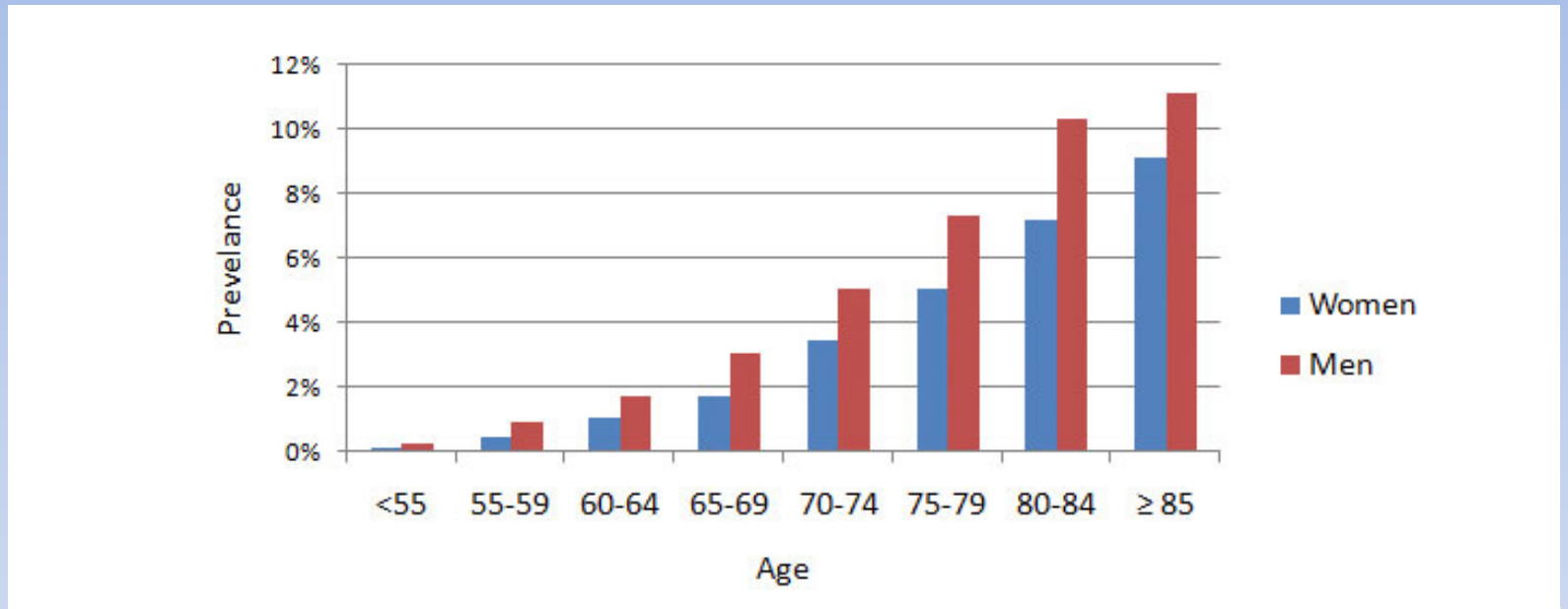
C- AVK seul

D- NACO seul

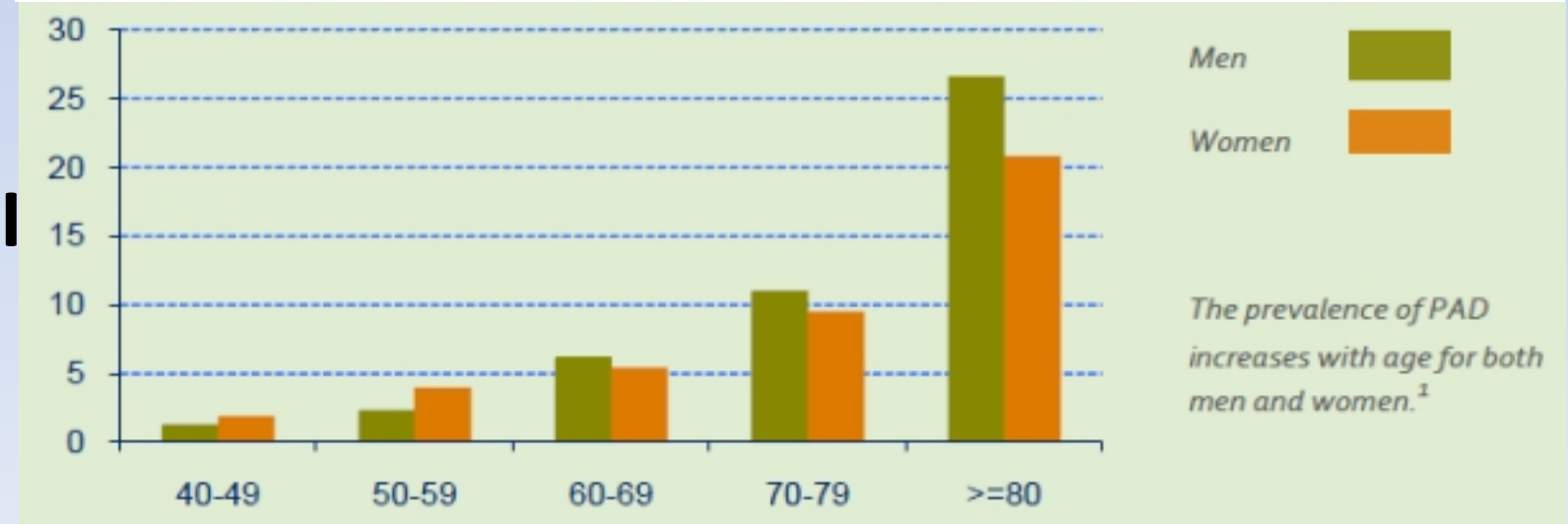
E- Aspirine seule

AOMI & FA: 2 maladies fréquentes avec l'âge

FA



AOMI



AOMI: risque élevé de FA: Etude CHS

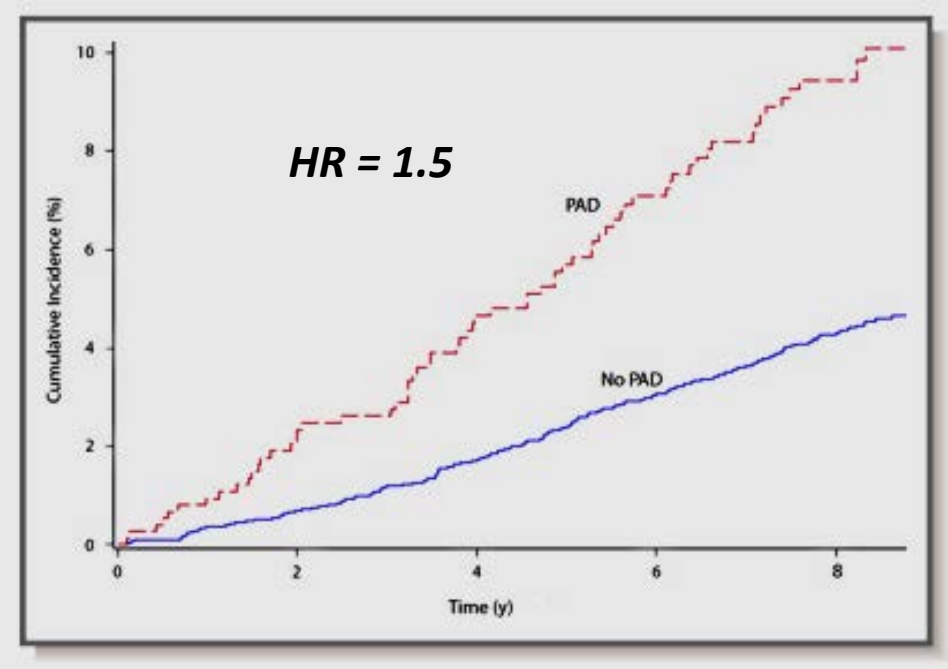
- 5143 participants sains, 11 ans de suivi
- Incidence de FA:
  - Sans AOMI: 23.3 / 1000 person-years
  - Avec AOMI: 32.9 / 1000 person-years
- L'apparition d'une AOMI au cours du temps était un facteur prédictif indépendant de survenue de FA: HR = 1,52
- A chaque baisse d'IPS de 0,10 = 6% d'augmentation de risque de FA

Griffin et al, Europace 2015

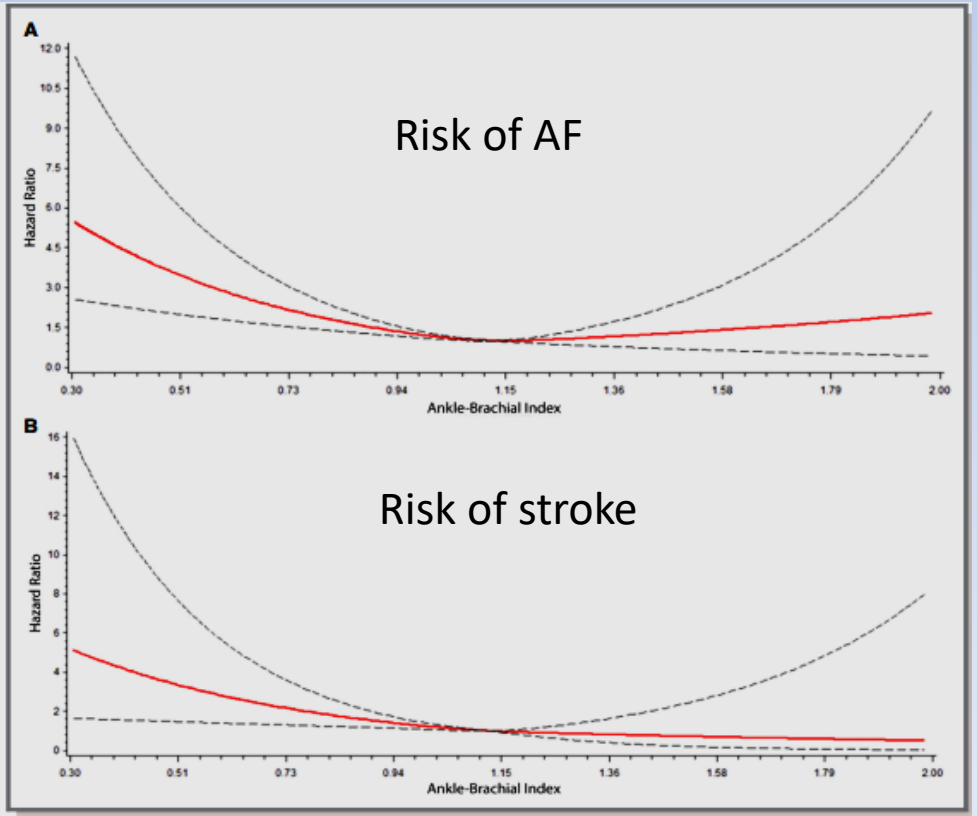
Peripheral Arterial Disease and Risk of Atrial Fibrillation and Stroke: The Multi-Ethnic Study of Atherosclerosis

Wesley T. O'Neal, MD, MPH; Jimmy T. Efird, PhD, MSc; Saman Nazarian, MD, PhD; Alvaro Alonso, MD, PhD; Susan R. Heckbert, MD, PhD; Elsayed Z. Soliman, MD, MSc, MS

- Etude MESA: 6800 participants sans ATCD CV



J Am Heart Assoc 2014

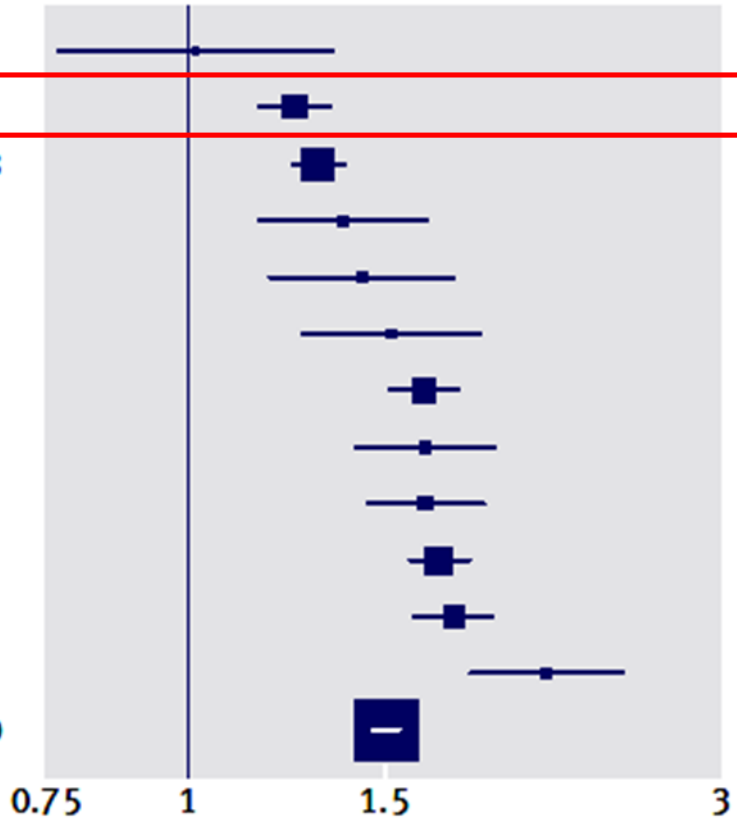


BMJ 2015

Usual blood pressure, peripheral arterial disease, and vascular risk: cohort study of 4.2 million adults

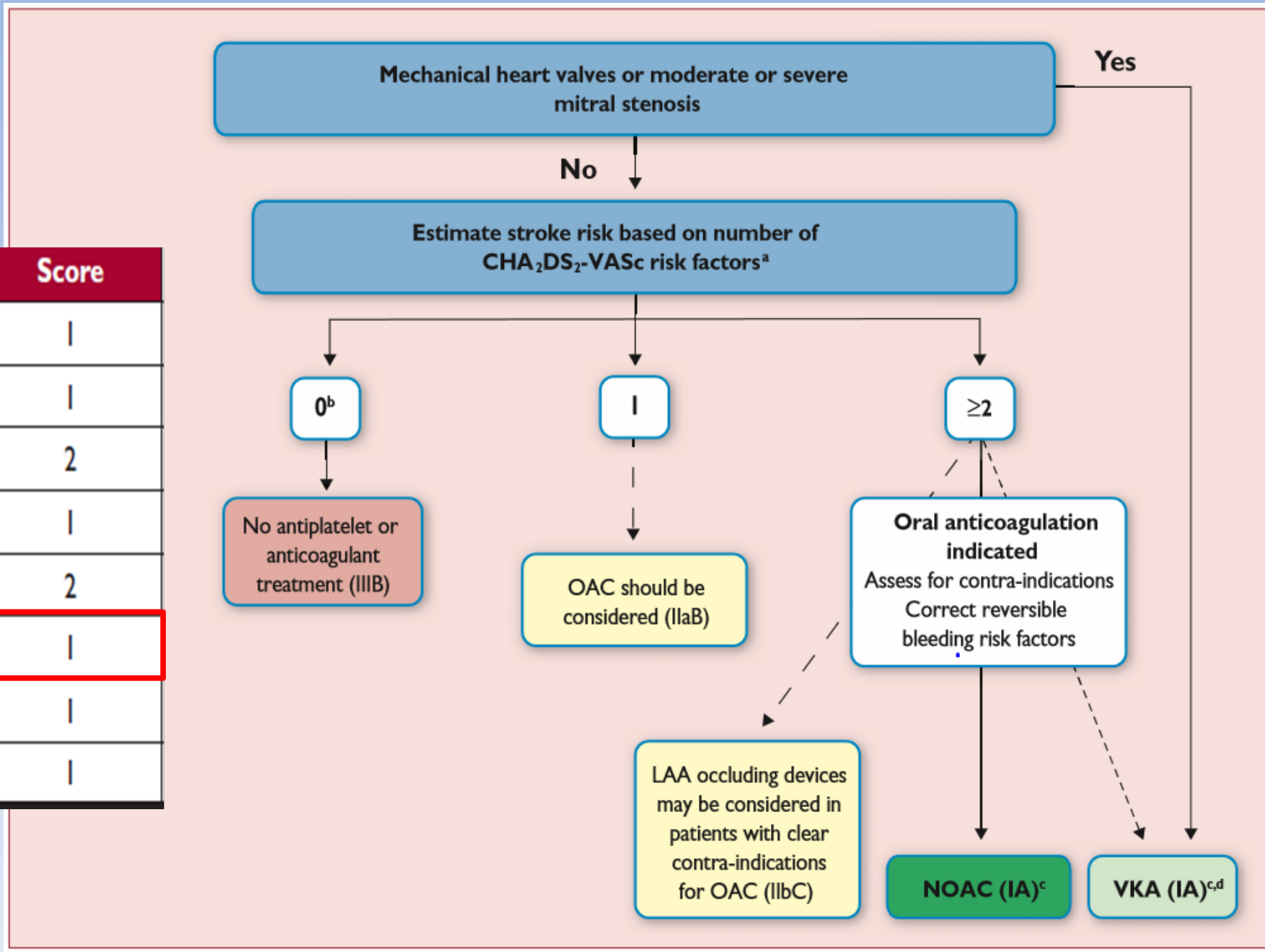
Connor A Emdin,[1] Simon G Anderson,[1] Thomas Callender,[1] Nathalie Conrad,[1] Gholamreza Salimi-Khorshidi,[1] Hamid Mohseni,[1] Mark Woodward,[2,3] Kazem Rahimi[1,4]

Outcome	No of events	Hazard ratio (95% CI)
Haemorrhagic stroke	8390	1.02 (0.77 to 1.35)
Atrial fibrillation	81 893	1.25 (1.16 to 1.34)
Chronic kidney disease	142 133	1.31 (1.25 to 1.38)
Valvular disease	18 027	1.38 (1.16 to 1.64)
Vascular dementia	7367	1.43 (1.19 to 1.73)
Pulmonary embolism	17 282	1.52 (1.27 to 1.83)
Heart failure	50 077	1.63 (1.52 to 1.75)
Ischaemic stroke	14 579	1.63 (1.42 to 1.88)
Deep vein thrombosis	38 056	1.63 (1.45 to 1.84)
Ischaemic heart disease	71 679	1.68 (1.58 to 1.79)
Stroke unspecified	37 142	1.73 (1.60 to 1.88)
Aortic aneurysm	6895	2.10 (1.79 to 2.45)
Any vascular event	493 520	1.51 (1.47 to 1.55)



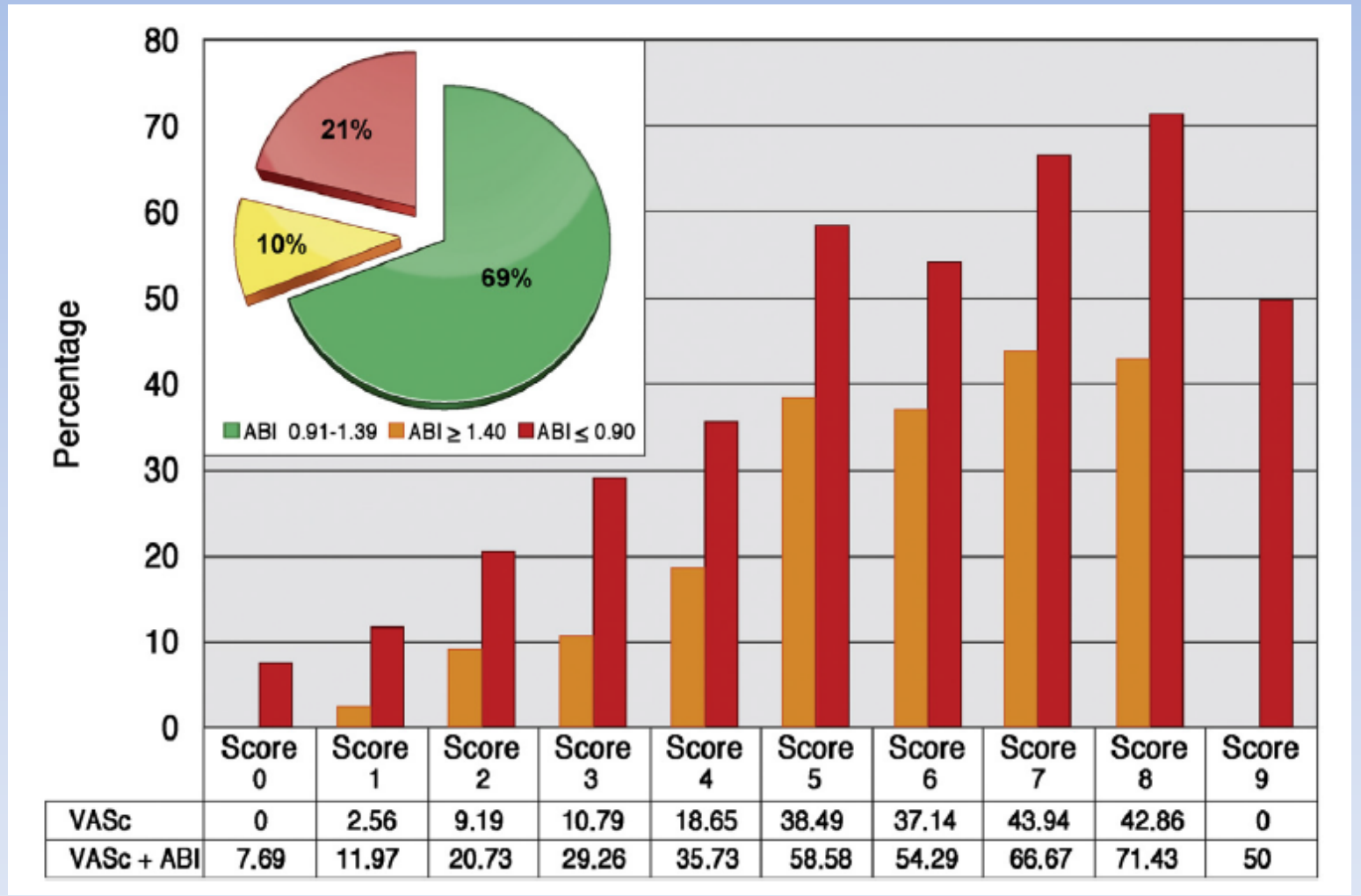
FA et anticoagulants: Recos ESC 2016

Risk factor	Score
Congestive heart failure/LV dysfunction	1
Hypertension	1
Age ≥75	2
Diabetes mellitus	1
Stroke/TIA/thrombo-embolism	2
Vascular disease[a]	1
Age 65–74	1
Sex category (i.e. female sex)	1



IPS chez les patients en FA

- ARAPACIS : 2027 pts hospitalisés pour FA non-valvulaire.
- IPS systématique.

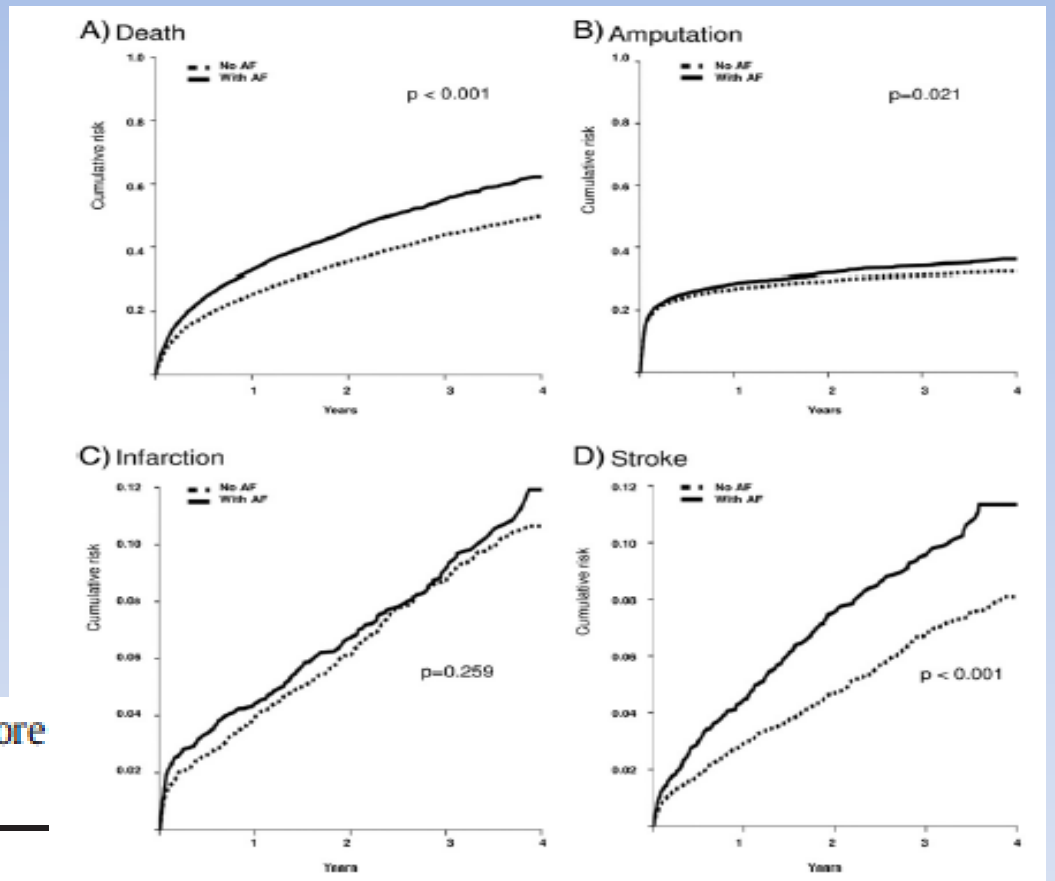


	Score 0	Score 1	Score 2	Score 3	Score 4	Score 5	Score 6	Score 7	Score 8	Score 9
VASc	0	2.56	9.19	10.79	18.65	38.49	37.14	43.94	42.86	0
VASc + ABI	7.69	11.97	20.73	29.26	35.73	58.58	54.29	66.67	71.43	50

Violi et al, JACC2013

Patients avec AOMI: la FA est pronostique

41,882 patients
hospitalisés pour AOMI
2009-2011

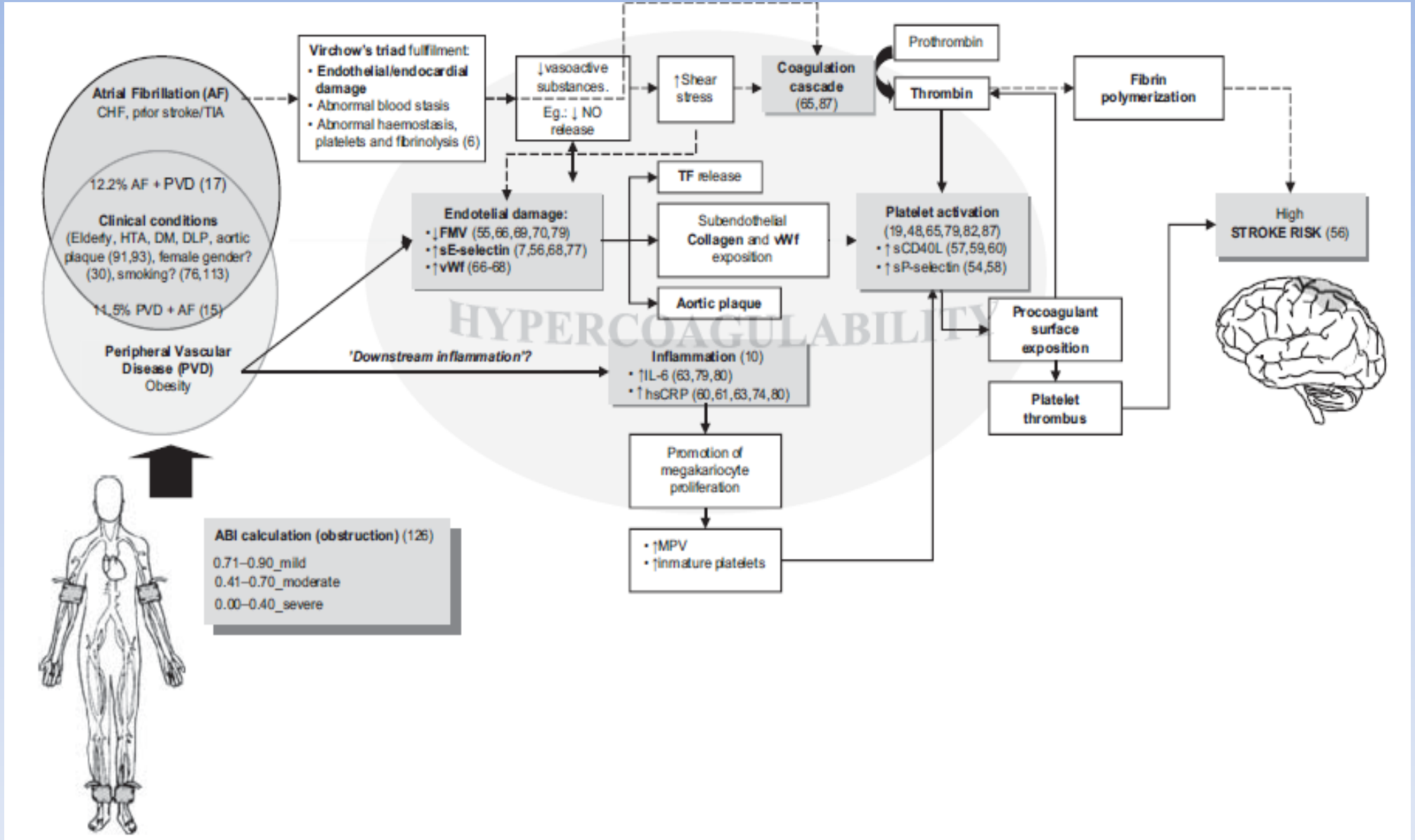


Cox regression analyses for long-term outcomes in 11,240 patients after propensity score matching.

	Death		Amputation		Ischemic stroke	
	HRR (95% CI)	p	HRR (95% CI)	p	HRR (95% CI)	p
AF	1.39 (1.32–1.47)	<**0.001**	1.08 (1.01–1.16)	**0.022**	1.51 (1.29–1.77)	<**0.001**

Wassmer et al, Int J C 2015

FA, AOMI & hypercoagulabilité



Jover et al, Ann Med 2012

FA & AOMI:

ANTICOAGULANTS, ANTIPLAQUETTAIRES OU LES 2?

AOMI en cas de FA: équation difficile

- 287 patients consécutifs anticoagulés pour FA, avec INR stabilisés sous AVK durant 6 mois (INR 2,0–3,0).

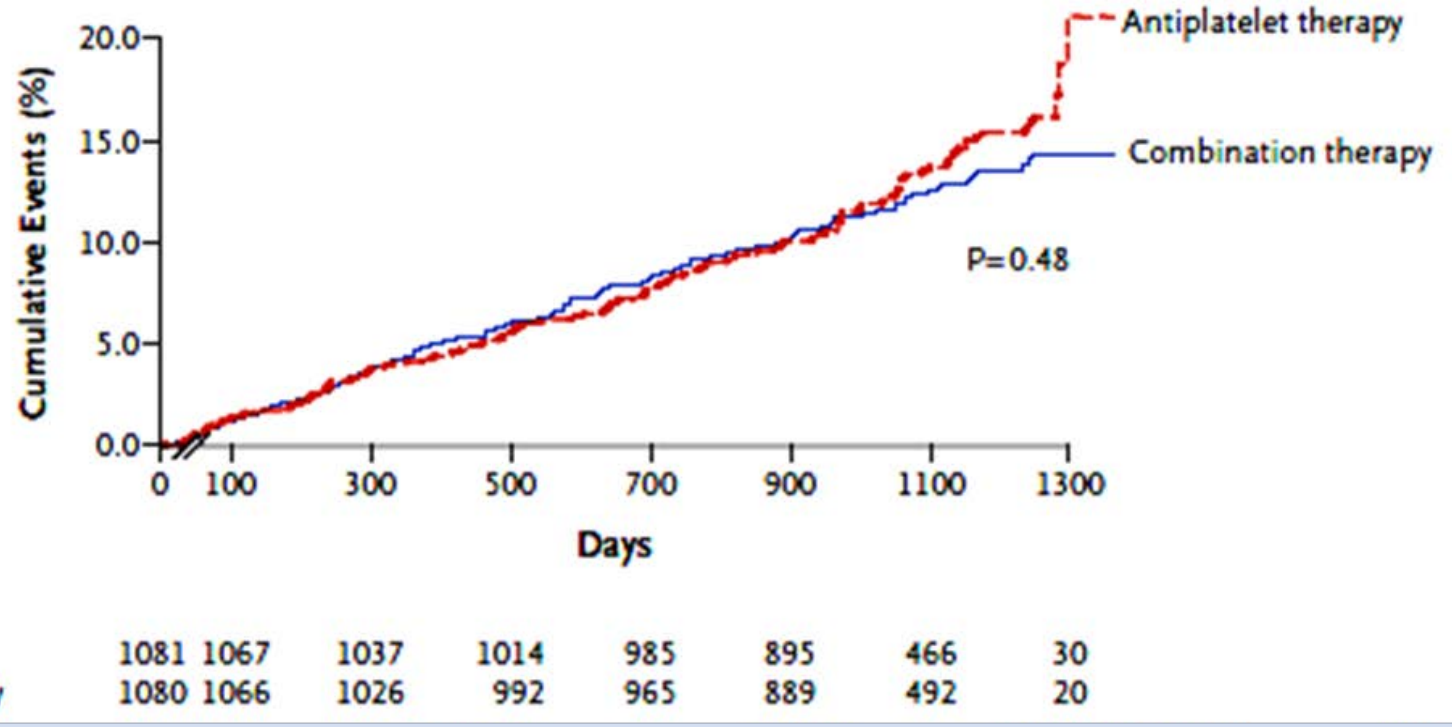
- IPS mesuré. IPS anormal dans 27% des cas:
  - ↑ risque de mortalité ajusté au score de CHADS. HR: 2,76 (p=0,033)
  - ↑ risque de saignement majeur même après ajustement au score HAS-BLED. HR: 2,47 (p=0,047).

Gallego et al, Eur J Clin Invest 2012

NEJM 2007

WAVE

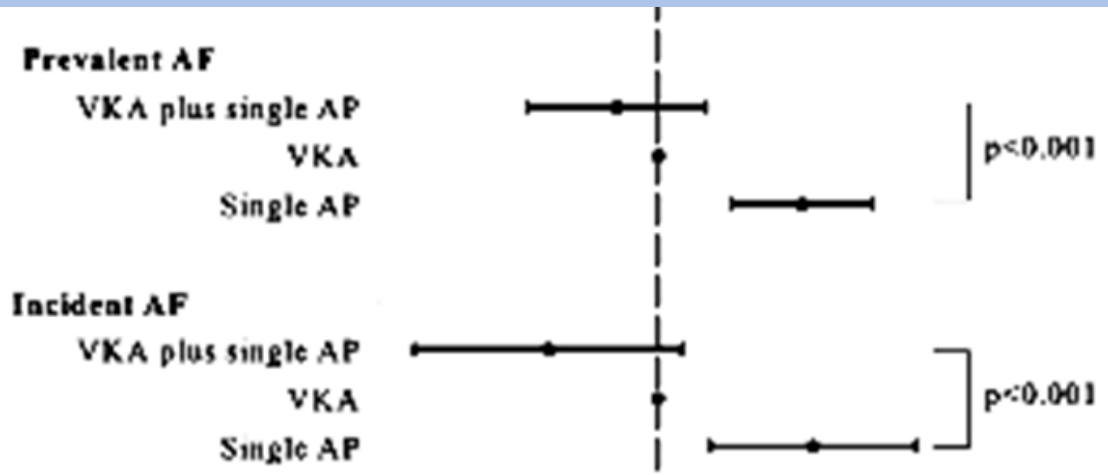
- 2161 patients avec AOMI
- Aspirine vs. Aspirine + AVK (INR 2-3)



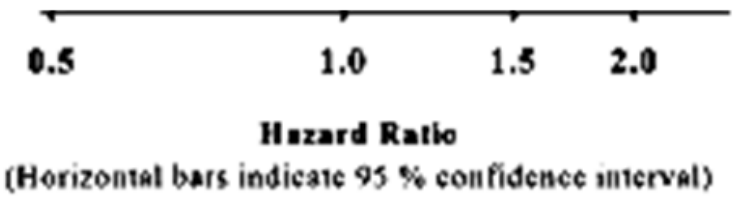
Fatal bleeding	10 (0.9)	3 (0.3)	3.34 (0.92–12.1)	0.05
Life-threatening bleeding	43 (4.0)	13 (1.2)	3.41 (1.84–6.35)	<0.001
Intracranial bleeding	14 (1.3)	0	15.2 (2.0–115.6)	0.001
Moderate bleeding	31 (2.9)	11 (1.0)	2.82 (1.43–5.58)	0.002
Life-threatening or moderate bleeding	74 (6.9)	24 (2.2)	3.21 (2.02–5.08)	<0.001

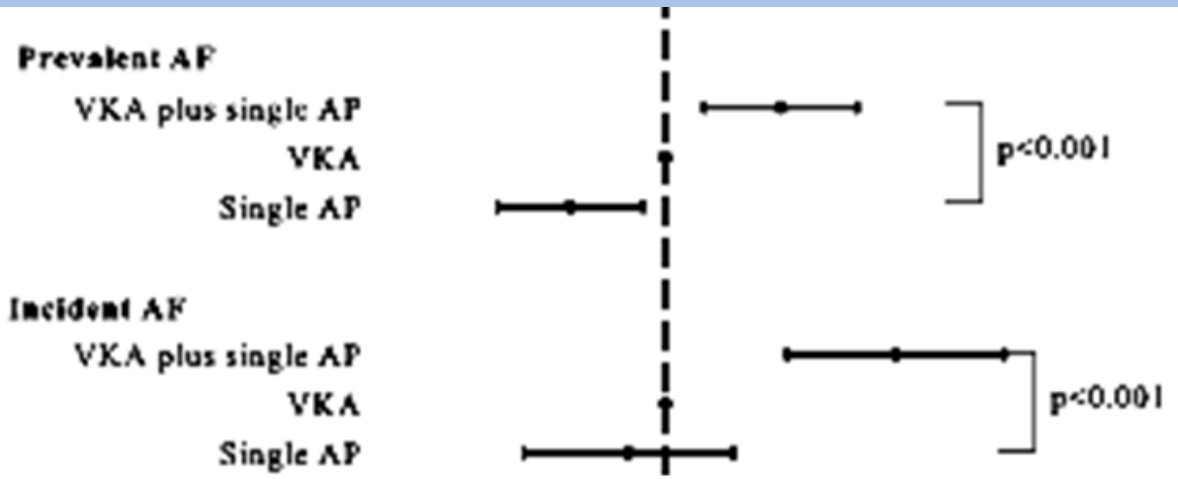
Antithrombotic Treatment in Patients With Heart Failure and Associated Atrial Fibrillation and Vascular Disease

A Nationwide Cohort Study

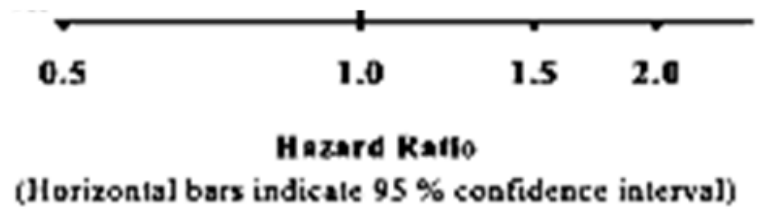


Arterial thrombo-embolism





Serious Bleeding



Lamberts et al, JACC 2014

BMJ 2008;336:614-5

CHANGE PAGE

Don't add aspirin for associated stable vascular disease in a patient with atrial fibrillation receiving anticoagulation

Gregory Y H Lip

KEY POINTS

Adding aspirin to warfarin does not seem to prevent stroke and vascular events in patients with atrial fibrillation and stable vascular disease

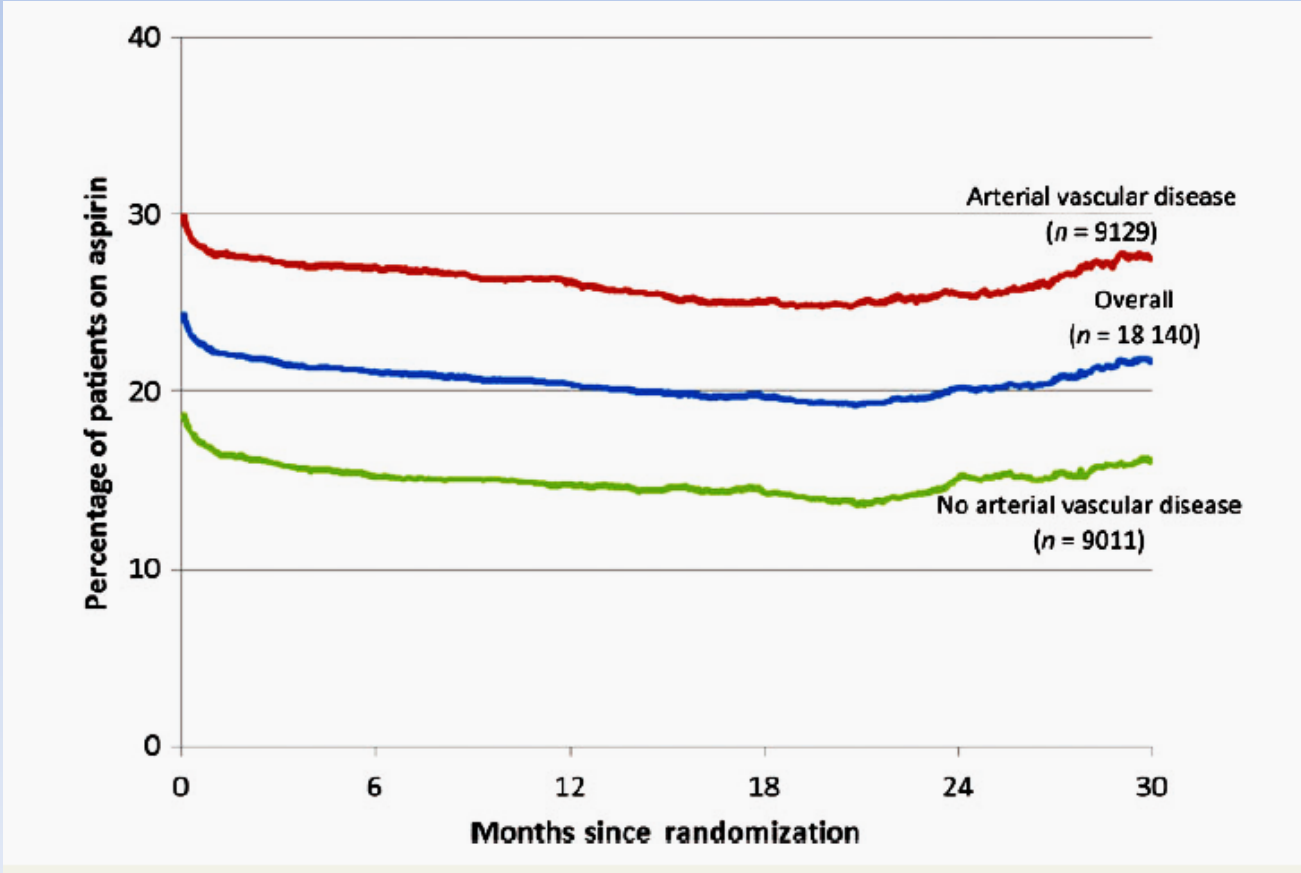
Bleeding risks are much higher in patients prescribed both warfarin and aspirin

We should stop prescribing aspirin plus warfarin to prevent stroke and vascular events in stable patients with atrial fibrillation who are receiving anticoagulation treatment

Apixaban vs. warfarin with concomitant aspirin in patients with atrial fibrillation: insights from the ARISTOTLE trial

Alexander et al, Eur Heart J 2013

- 18 201 patients en FA parox. ou perm/persistante
- + 1 FdR:
  - Age >75 ans
  - Diabétique
  - HTA
  - Insuff. Cardiaque
  - Dysfonction VG
  - ATCD AVC
- Warfarine vs. Apixaban
- 24% étaient aussi sous Aspirine



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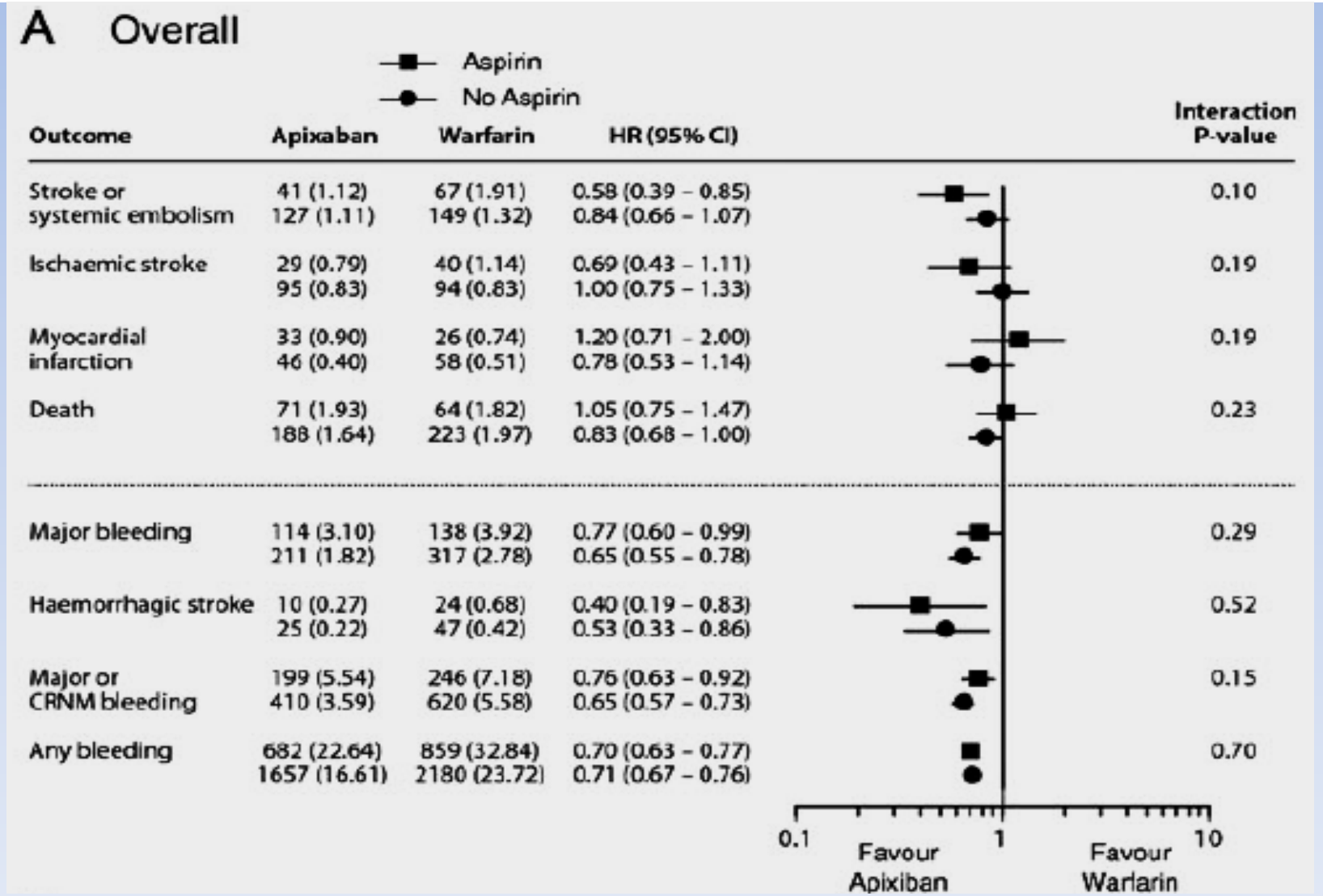
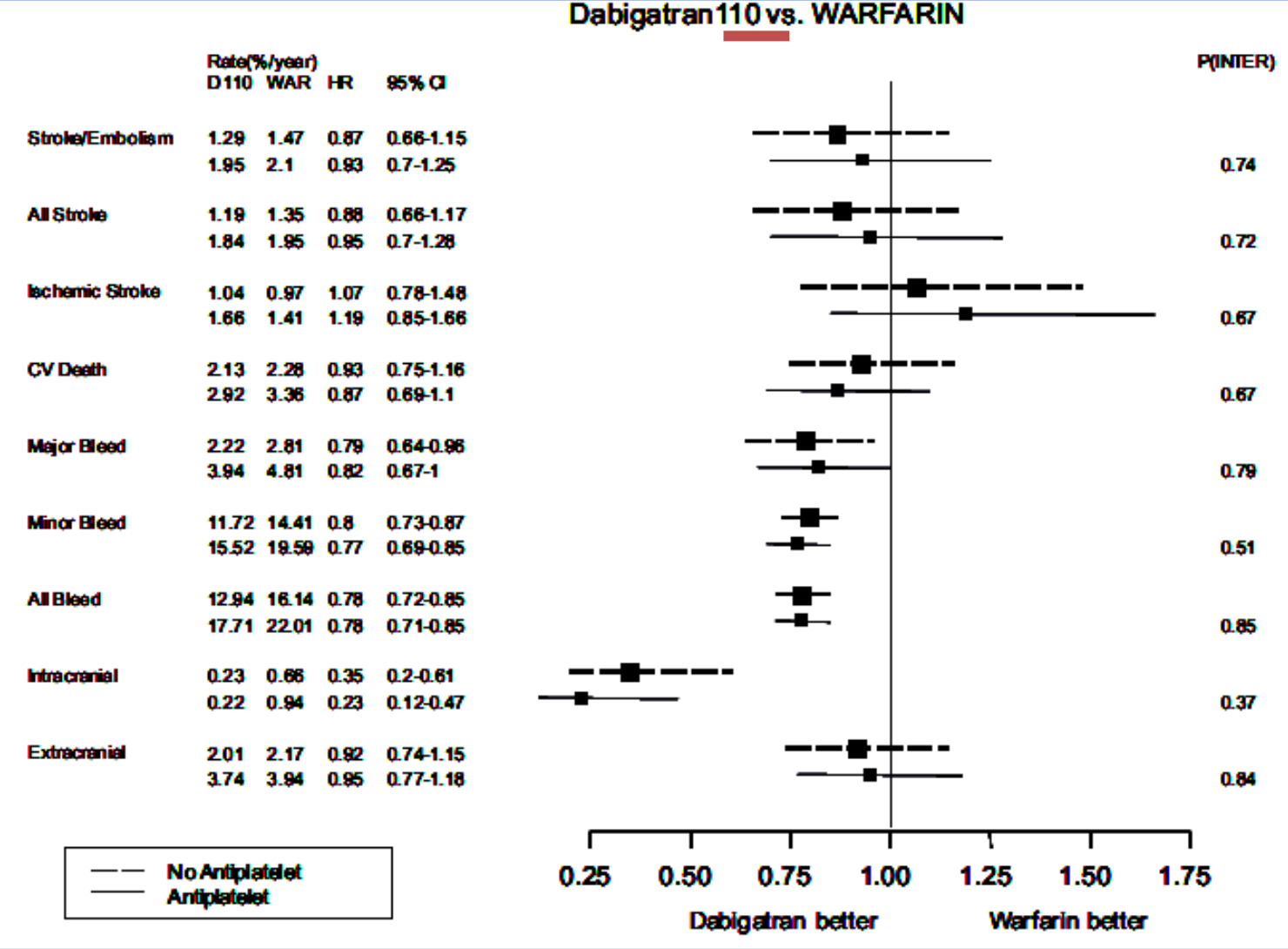
Alexander et al, Eur Heart J 2013



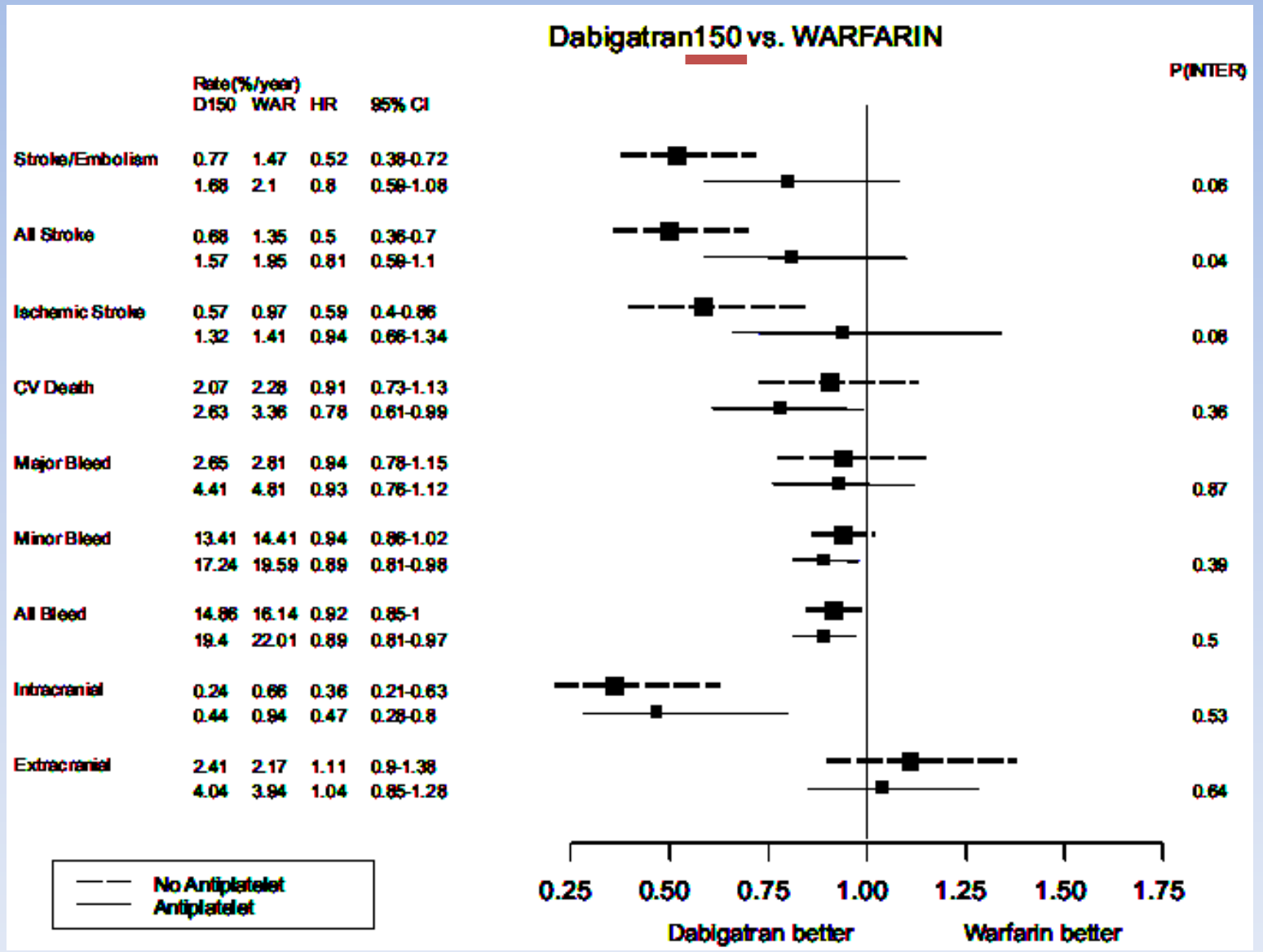
Concomitant Use of Antiplatelet Therapy with Dabigatran or Warfarin in the Randomized Evaluation of Long-Term Anticoagulation Therapy (RE-LY) Trial

- 38% ont reçu à un moment durant le protocole un AAP (aspirine ou clopidogrel)



Dans et al, Circulation 2013

Concomitant Use of Antiplatelet Therapy with Dabigatran or Warfarin in the Randomized Evaluation of Long-Term Anticoagulation Therapy (RE-LY) Trial



Dans et al, Circulation 2013

Stroke
JOURNAL OF THE AMERICAN HEART ASSOCIATION
American Stroke Association
A Division of American Heart Association

Intracranial Hemorrhage in Atrial Fibrillation Patients During Anticoagulation With Warfarin or Dabigatran : The RE-LY Trial

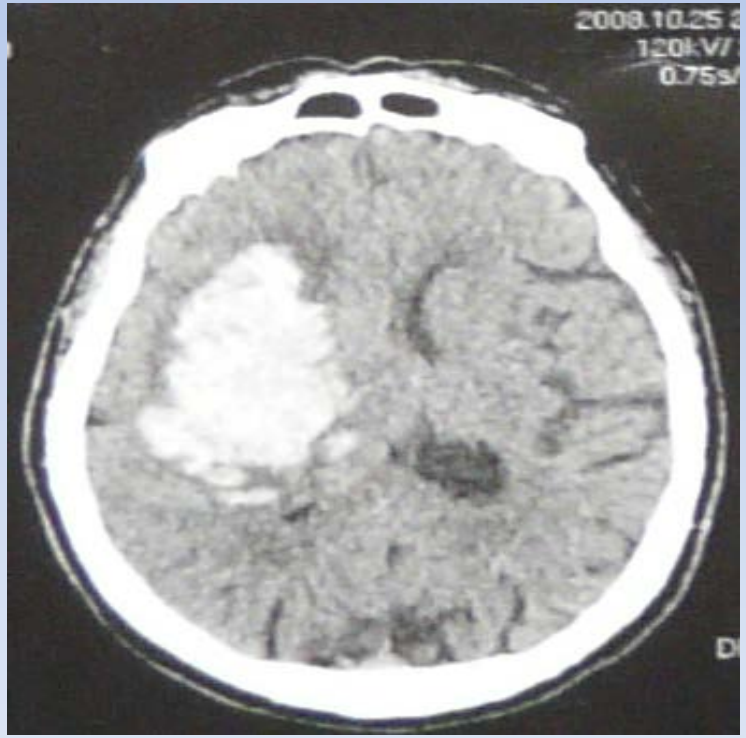


Table 3. Features Independently Predictive of Intracranial Hemorrhage*

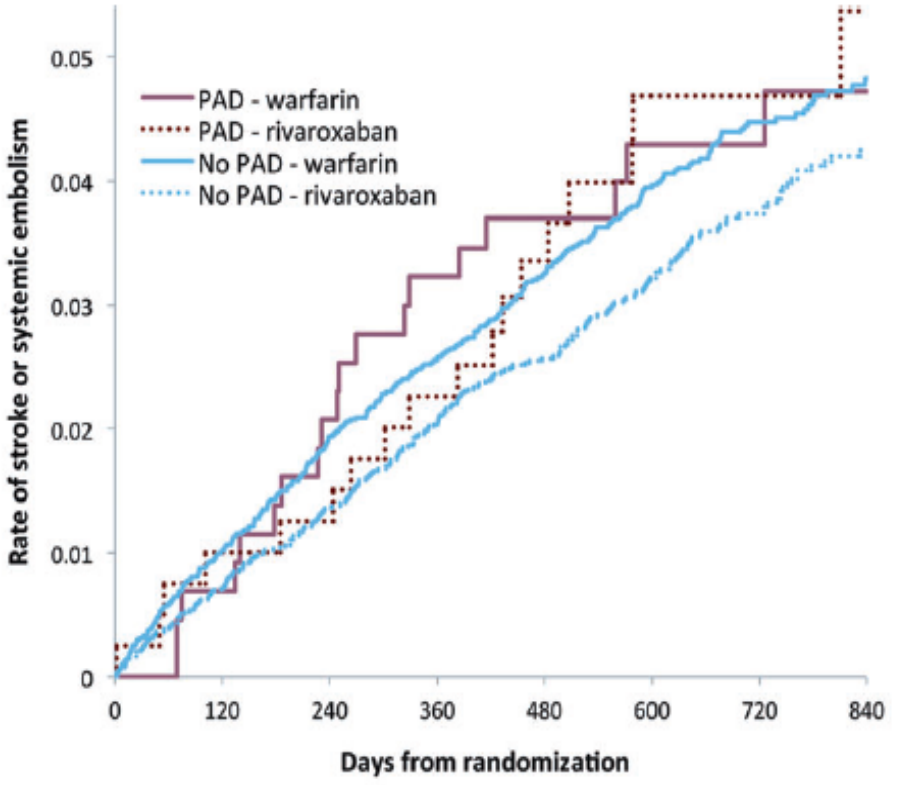
	Feature	Relative Risk	*P* Value
All participants			
All intracranial hemorrhages (n=153)	Age (per y)	1.1	<0.001
	White	0.68	0.02
	Previous stroke/TIA	1.8	0.001
	Assigned warfarin	2.9	<0.001
	Aspirin use	1.6	0.01

Lip GYh, BMJ 2008

Schuyler Jones Eur Heart J 2014

Efficacy and safety of rivaroxaban compared with warfarin in patients with peripheral artery disease and non-valvular atrial fibrillation: insights from ROCKET AF

5% des participants avaient une AOMI



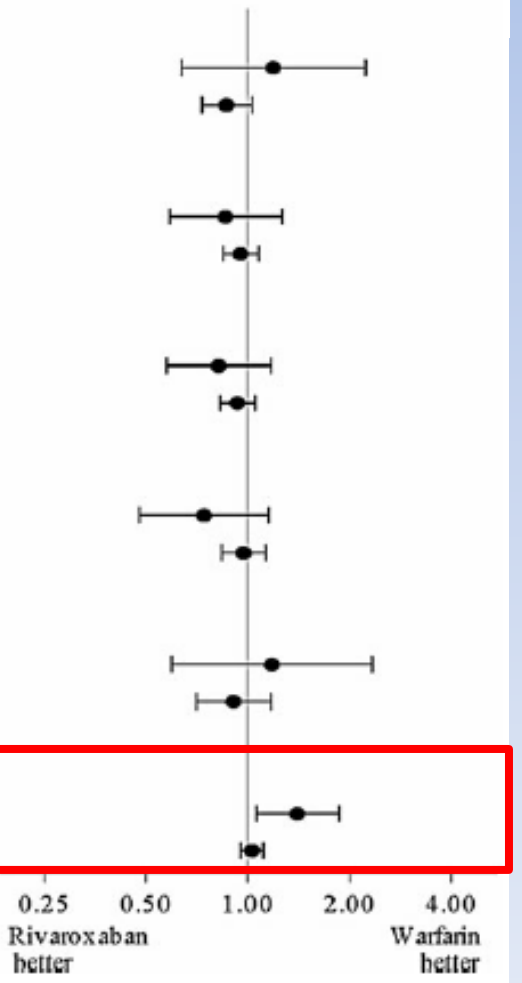
PAD - warfarin	434	431	425	419	356	306	219	137
PAD - rivaroxaban	398	394	393	389	314	260	191	120
No PAD - warfarin	6656	6589	6527	6476	5374	4272	3145	1943
No PAD - rivaroxaban	6683	6635	6592	6535	5454	4355	3201	1995

Cumulative rate of stroke or systemic embolism in patients classified by peripheral artery disease and treatment assignment.

Schuyler Jones Eur Heart J 2014

Efficacy and safety of rivaroxaban compared with warfarin in patients with peripheral artery disease and non-valvular atrial fibrillation: insights from ROCKET AF

Outcome	Interaction P-value	Hazard ratio	95% CI
Stroke/systemic embolism	0.34		
PAD		1.19	0.63, 2.22
No PAD		0.86	0.73, 1.02
Stroke/SE/vasc death	0.61		
PAD		0.86	0.59, 1.26
No PAD		0.95	0.85, 1.07
All-cause death	0.50		
PAD		0.82	0.57, 1.17
No PAD		0.93	0.83, 1.05
Vascular death	0.26		
PAD		0.74	0.48, 1.15
No PAD		0.97	0.84, 1.13
Myocardial infarction	0.49		
PAD		1.18	0.59, 2.33
No PAD		0.91	0.70, 1.17
Major/NMCR bleeding	0.037		
PAD		1.40	1.06, 1.86
No PAD		1.03	0.95, 1.11



En cas de revascularisation récente

- **ESC Guidelines (2011)**

- AVK au lieu d'aspirine ou du clopidogrel lors de la double thérapie?
- EVITER la triple therapie+++
- Discussion au cas par cas
- NACOs ??

Dual antiplatelet therapy with aspirin and a thienopyridine for at least one month is recommended after infrainguinal bare-metal-stent implantation.	I	C	
Antiplatelet treatment with aspirin or a combination of aspirin and dipyridamole is recommended after infrainguinal bypass surgery.	I	A	308
Antithrombotic treatment with vitamin K antagonists may be considered after autogenous vein infrainguinal bypass.	IIb	B	309
Dual antiplatelet therapy combining aspirin and clopidogrel may be considered in the case of below-knee bypass with a prosthetic graft.	IIb	B	312

Tendera, Aboyans et al, Eur Heart J 2011

Conclusions

- ***FA et AOMI : une association fréquente***
- ***FA et AOMI: Un défi de prise en charge***
  - Le risque thrombo-embolique est plus élevé (cf CHADS-VASc)
  - Le risque hémorragique est aussi plus élevé
  - Aspirine + AVK vs. AVK seules: plus de risque que de bénéfice
  - NACO et Aspirine dans l'AOMI: peu de données mais semble au moins aussi dangereux (voire plus ?) que l'association AVK-aspirine.
  - Stenting: envisager aspirine + anticoagulant sur la plus courte durée (1 mois?) puis anticoagulant seul. Penser à la protection gastrique+++
  - Des essais spécifiques sont nécessaires
  - En attendant: anticogulants seuls dans la grande majorité des cas.