Continue

إرشادات acc / aha لإدارة المرضى الذين يعانون من ua / nstemi guidelines

Sep 27, 2011 The document, which addresses recent research and approvals of new drugs like ticagrelor, updates sections of the original 2007 guideline and replaces the 2011 Focused Update. While the updated guideline continues to recommend that all patients receive aspirin immediately after hospitalization, and continue as long as it is tolerated, other key recommendations include: The updated guideline also recommends consideration of prasugrel and ticagrelor, approved by the FDA in 2011, as a treatment option in addition to clopidogrel. Ticagrelor was found to be superior to clopidogrel in the PLATO trial, and was studied and approved for use in all patients, including medically-treated patients and patients undergoing revascularization procedures. Prasugrel was superior to clopidogrel in the TRITON-TIMI 38 trial. It was studied and approved for use in the cardiac cath laboratory in patients in whom coronary anatomy is known and who are planned to undergo a PCI. "The AHA and ACCF constantly update their guidelines so that physicians can provide patients with the most appropriate, aggressive therapy with the goal of improving health and survival," said Hani Jneid, MD, FACC, lead author of the update and an assistant professor of medicine and director of interventional cardiology research at Baylor College of Medicine, and an interventional cardiologist at the Michael E. DeBakey VA Medical Center in Houston. In the case of this update "we have put [ticagrelor] on equal footing with the two other antiplatelet medications, clopidogrel and prasugrel." Also included in the update, the guideline authors encourage clinicians and hospitals to participate in a standardized quality-of-care data registry designed to track and measure outcomes, complications and adherence to evidence-based recommendations. They note that these registries "may prove pivotal in addressing opportunities for quality improvement at the local, regional and national level, and include the elimination of health care disparities and conduct of comparative effectiveness research." The document was endorsed by the American College of Emergency Physicians, Society for Cardiovascular Angiography Interventions, and Society of Thoracic Surgeons. < Back to Listings Contact: Amy Murphy, amurphy@acc.org, 202-375-6476 The American College of Cardiology and the American Heart Association have jointly released revised Guidelines for the Management of Patients with Unstable Angina (UA)/Non-ST- Elevation Myocardial Infarction (NSTEMI). Major changes to the guidelines include: suggesting an initial non-invasive set of preliminary tests, such as a stress test, echocardiogram or radionuclide angiogram; recommending the use of anti-platelet therapy clopidogrel for at least one year after receiving a drug-eluting stent; highlighting the importance of more intense lipid and blood pressure control; and advising cessation of non-steroidal anti-inflammatory drugs (NSAIDS) use for all UA/NSTEMI patients during hospitalization. Coronary artery disease (CAD) is the leading cause of death in the United States, and UA and NSTEMI are acute manifestations of this condition. In 2004, the National Center for Health Statistics reported 669,000 hospitalizations for UA and 896,000 for myocardial infarction. Unstable angina, which causes chest pain and discomfort, occurs when a coronary artery is partially blocked. Myocardial infarction, or heart attack, occurs when a coronary artery is completely blocked, cutting off blood flow to the heart resulting in death of heart muscle. The ability to detect and treat these conditions earlier has greatly improved over the last several years. “New evidence from pivotal trials over the past five years has been gathered together in these guidelines to give physicians up-to-date and detailed information on which treatment options will provide the best possible outcomes for their patients,” said Nanette K. Wenger, M.D., F.A.C.C., F.A.H.A., a member of the guidelines writing committee and professor of medicine in the Division of Cardiology at Emory University School of Medicine in Atlanta. “This is a major educational document for health professionals, and I trust it will become part of the core teaching for medical students, residents and graduate physicians.” The guidelines, which were last published in 2002, have been developed for cardiovascular specialists, emergency room physicians and healthcare professionals who evaluate and treat patients with acute coronary syndrome. They focus on the diagnosis, treatment and management of patients with UA and the closely related condition of NSTEMI. The 2002 guidelines recommended an early invasive strategy – diagnostic angiography and revascularization – as the way to treat UA/NSTEMI patients. The revised guidelines differentiate more extensively between high- and low-risk UA/NSTEMI groups, and recommend an early invasive strategy for unstable and high risk patients, with an initial conservative (non-invasive) strategy – stress test, echocardiogram or radionuclide study – as a possible treatment option in stabilized UA/NSTEMI patients and low risk patients. Risk status is determined by risk scores. For clinical practitioners, the revised guidelines emphasize secondary prevention, recommendations that should be continued after the UA/NSTEMI patient is discharged from the hospital to reduce risk of a recurrent heart attack. “We are emphasizing the use of ACE inhibitors---drugs that protect the muscle--- and prescribing aldosterone receptor blockade, a new drug category that wasn’t available previously for people with heart failure,” said Wenger. “High-dose antioxidant vitamin supplements such as beta carotene, vitamins E and C and folic acid for secondary prevention are no longer recommended because results from clinical trials have shown no benefit and possible harm.” There is also a greater emphasis on smoking cessation. Also new in the guidelines is the call for more intense lipid and blood pressure control. More stringent LDL cholesterol-lowering therapy and blood pressure management is recommended for UA/NSTEMI patients. LDL (“bad” cholesterol) should be lower than 100 mg/dL and ideally reduced to 70 mg/dL. Blood pressure should be lower than 140/90 and for those with diabetes or chronic kidney disease, a reading lower than 130/80 is recommended. Because platelets are thought to play a key role in recurrent heart attack, the anti-platelet therapy clopidogrel is now recommended for at least one year after placement of a drug-eluting stent and shorter term for bare metal stent and with medical therapy. “In addition we are emphasizing the value of intensive, long-term platelet therapy,” said Wenger. Additional updates to the guidelines include recommendations to discontinue the use of hormone replacement therapy in postmenopausal women; add troponin biomarkers as markers of cardiac damage and B-type natriuretic peptide (BNP) markers as potentially useful for cardiac risk assessment; and stop the usage of non-steroidal anti-inflammatory drugs (NSAIDS) for all UA/NSTEMI patients during hospitalization. Members of the writing committee include Jeffrey L. Anderson, M.D., Chair; Cynthia D. Adams, R.N., Ph.D.; Elliott M. Antman, M.D.; Charles R. Bridges, S.C.D., M.D.; Robert M. Califf, M.D.; Donald E. Casey, Jr, M.D., M.P.H., M.B.A.; William E. Chavey, II, M.D.; Francis M. Fesmire, M.D.; Judith S. Hochman, M.D.; Thomas N. Levin, M.D.; A. Michael Lincoff, M.D.; Eric D. Peterson, M.D., M.P.H.; Pierre Theroux, M.D.; Nanette Kass Wenger, M.D. and R. Scott Wright, M.D. Full text of the Guidelines will be published in the August 14, 2007 issues of the Journal of the American College of Cardiology, and Circulation: Journal of the American Heart Association, and will be posted ahead of print on the ACC (www.acc.org) and AHA (www.americanheart.org) Web sites on August 6. ### About the American College of Cardiology (ACC): The American College of Cardiology is leading the way to optimal cardiovascular care and disease prevention. The College is a 34,000-member nonprofit medical society and bestows the credential Fellow of the American College of Cardiology upon physicians who meet its stringent qualifications. The College is a leader in the formulation of health policy, standards and guidelines, and is a staunch supporter of cardiovascular research. The ACC provides professional education and operates national registries for the measurement and improvement of quality care. For more information visit www.acc.org. About the American Heart Association (AHA): Founded in 1924, the American Heart Association today is the nation’s oldest and largest voluntary health organization dedicated to reducing disability and death from diseases of the heart and stroke. These diseases, America’s No. 1 and No. 3 killers, and all other cardiovascular diseases claim over 870,000 lives a year. In fiscal year 2005–06 the association invested over $543 million in research, professional and public education, advocacy and community service programs to help all Americans live longer, healthier lives. To learn more, call 1-800-AHA-USA1 or visit americanheart.org. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Heidenreich PA, Bozkurt B, Aguilar D, Allen LA, Byun JJ, Colvin MM, Deswal A, Drazner MH, Dunlay SM, Evers LR, Fang JC, Fedson SE, Fonarow GC, Hayek SS, Hernandez AF, Khazanie P, Kittleson MM, Lee CS, Link MS, Milano CA, Nnacheta LC, Sandhu AT, Stevenson LW, Vardeny O, Vest AR, Yancy CW; ACC/AHA Joint Committee Members. Heidenreich PA, et al. Circulation. 2022 May 3;145(18):e895-e1032. doi: 10.1161/CIR.0000000000001063. Epub 2022 Apr 1. Circulation. 2022. PMID: 35363499 Review. Create Free Account or UA/NSTEMI Background: In 2007, the American College of Cardiology/American Heart Association (ACC/AHA) published new guidelines for the diagnosis and management of patients with unstable angina/non-ST segment elevation myocardial infarction (UA/NSTEMI). These guidelines include some important updates on the use of clopidogrel, fondaparinux, bivalirudin and low-molecular-weight heparins (LMWHs) all of which have published landmark clinical trials in patients with acute coronary syndromes (ACS) since the publication of the 2002 guidelines. While these 2007 guidelines are more comprehensive and up-to-date compared with the recommendations published in 2002, they also raise many questions for practising emergency physicians and cardiologists. Methods: This article presents a critical review of the 2007 ACC/AHA UA/NSTEMI guidelines, highlighting some of the areas of controversy, with the aim of providing some further guidance to practising physicians. Conclusions: Despite recent updates to the ACC/AHA UA/NSTEMI guidelines, additional factors need to be taken into consideration in the management of UA/NSTEMI patients. Integrating initial responses with early or selectively invasive strategies and the risks of complications in subsequent procedures require careful consideration. Protocol development within an institution is required to risk-stratify patients rapidly, provide optimum precatheterisation medical management and allow seamless and rapid transitions to the catheterisation laboratory in patients at risk for adverse events.