Chest Pain in Everyday Practice

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THIS IS MODERN MEDICINE


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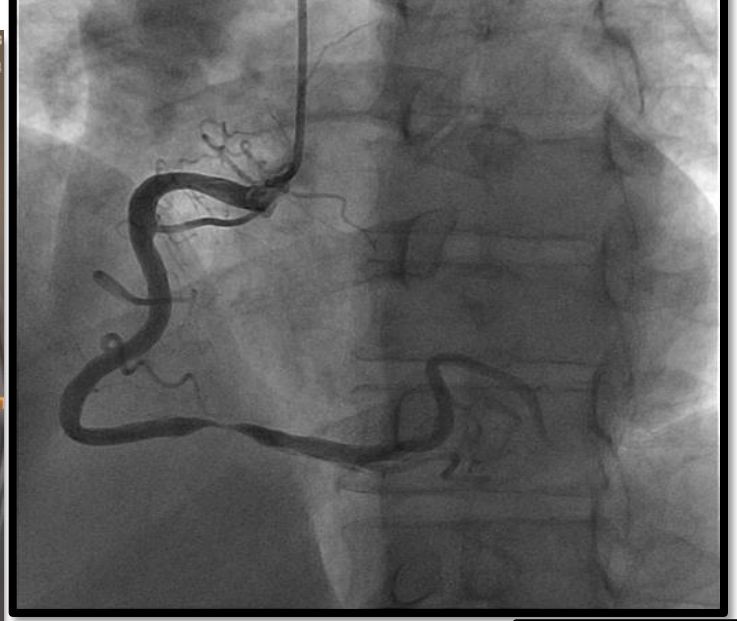

Stent Thrombosis

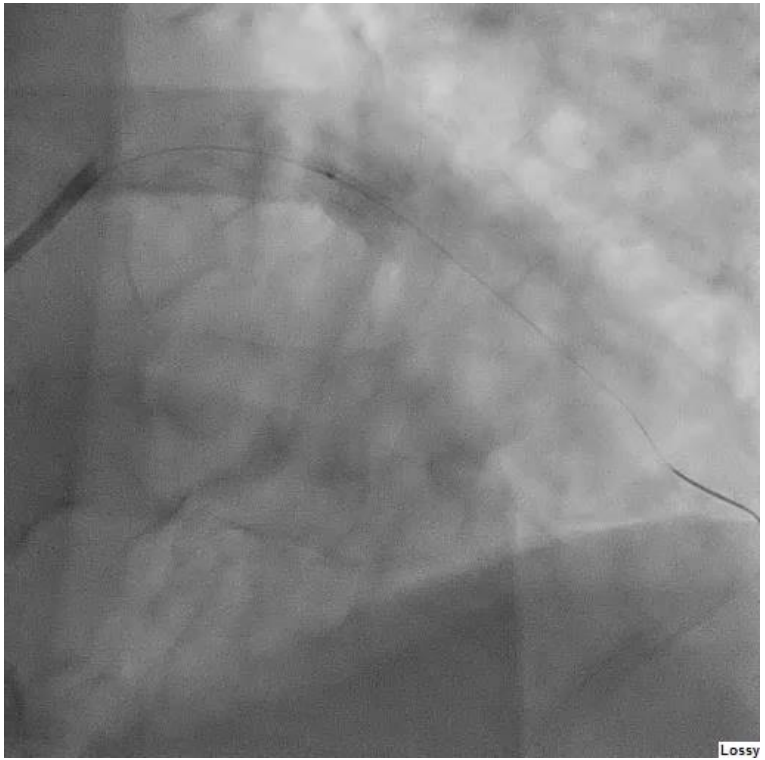

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Figure 1

Central illustration: Clinical presentations of CCS and mechanisms of myocardial ischaemia

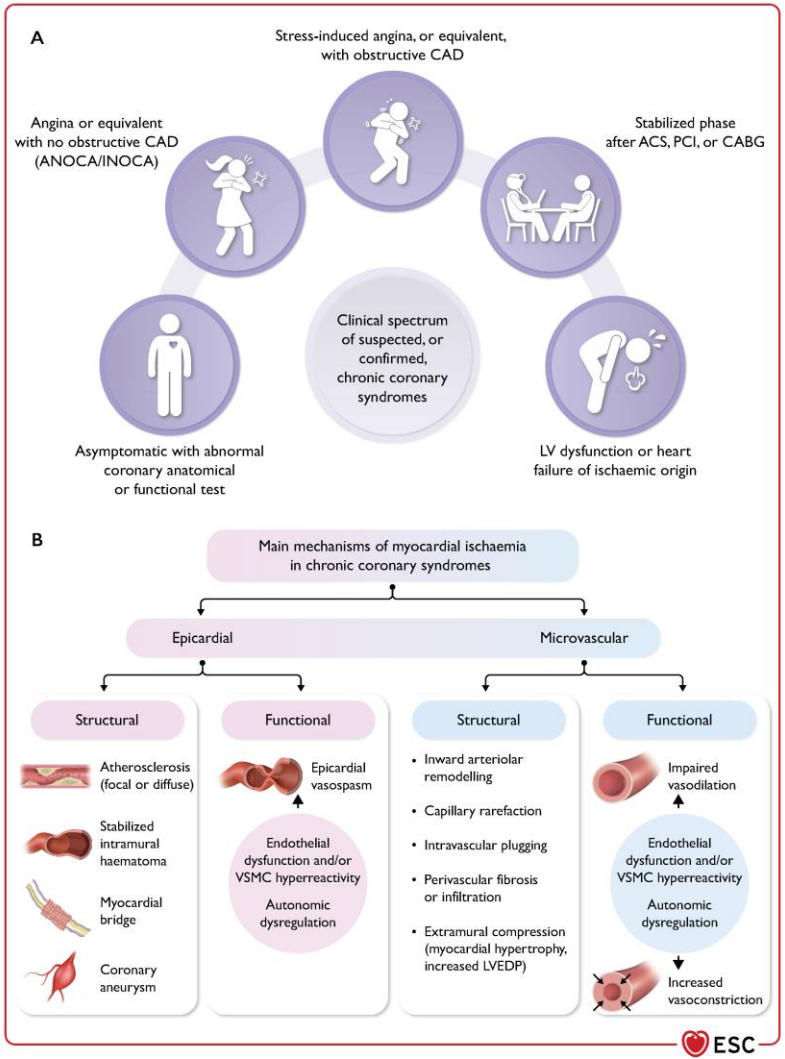

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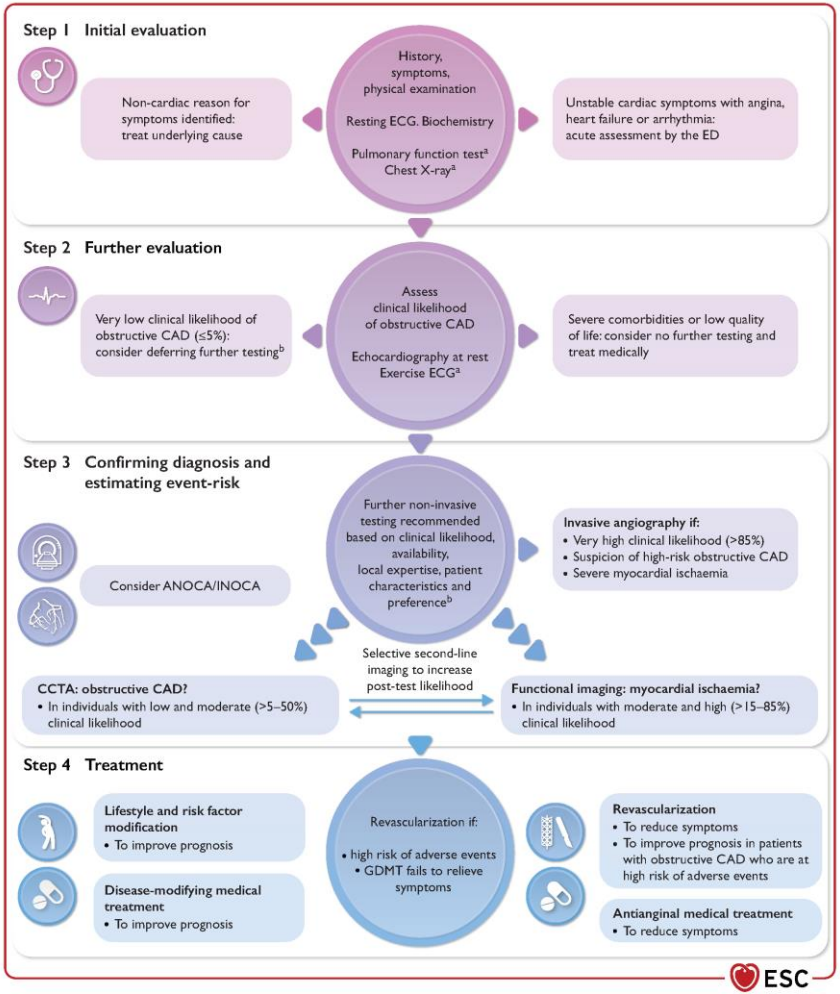
Figure 2

Stepwise approach to the initial management of individuals with suspected CCS



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ESC

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Figure 3

Main CCS Symptoms: angina and exertional dyspnoea

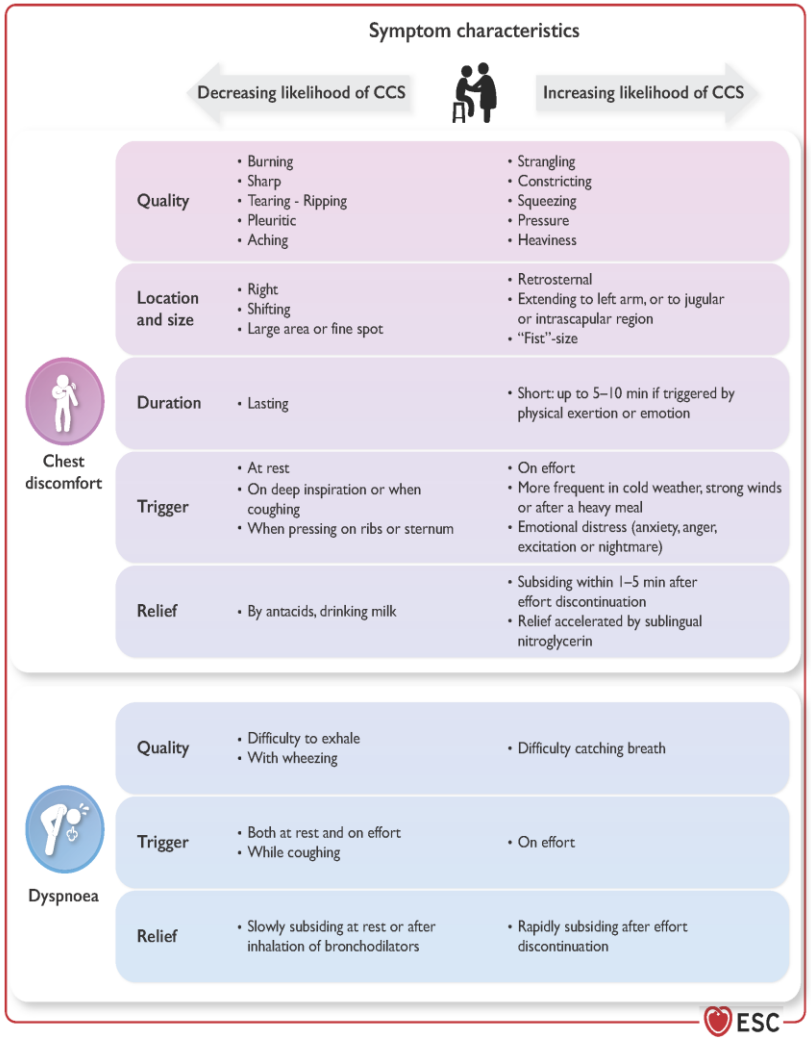

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Figure 4

Estimation of the likelihood of obstructive CAD

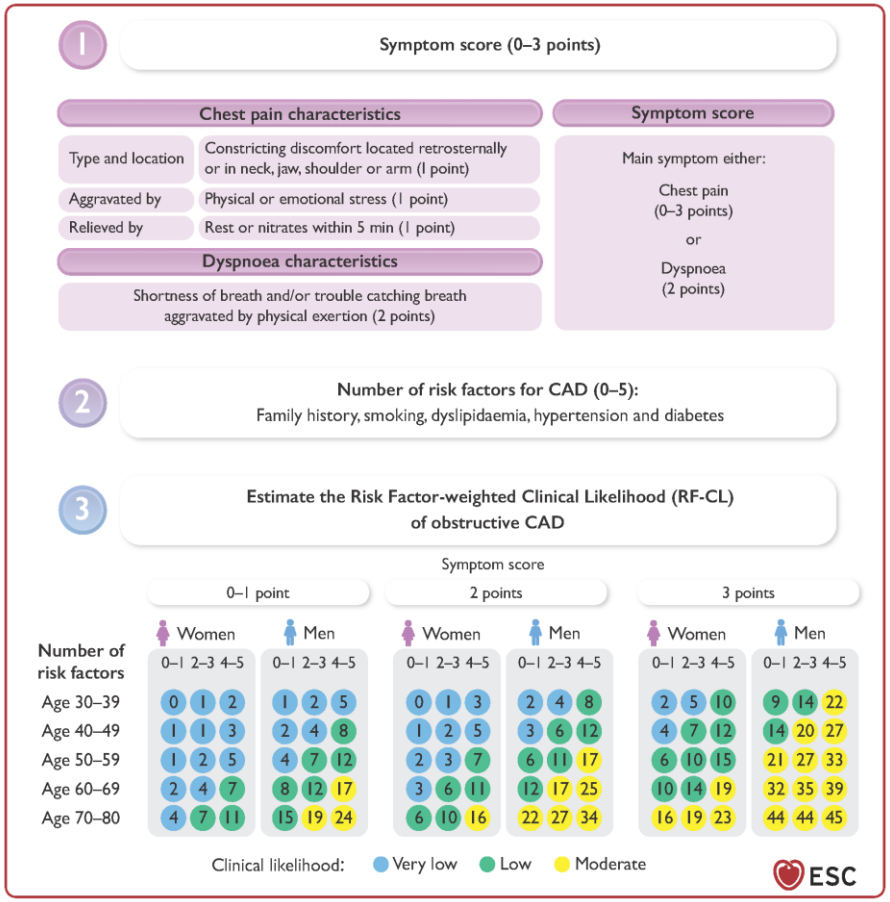

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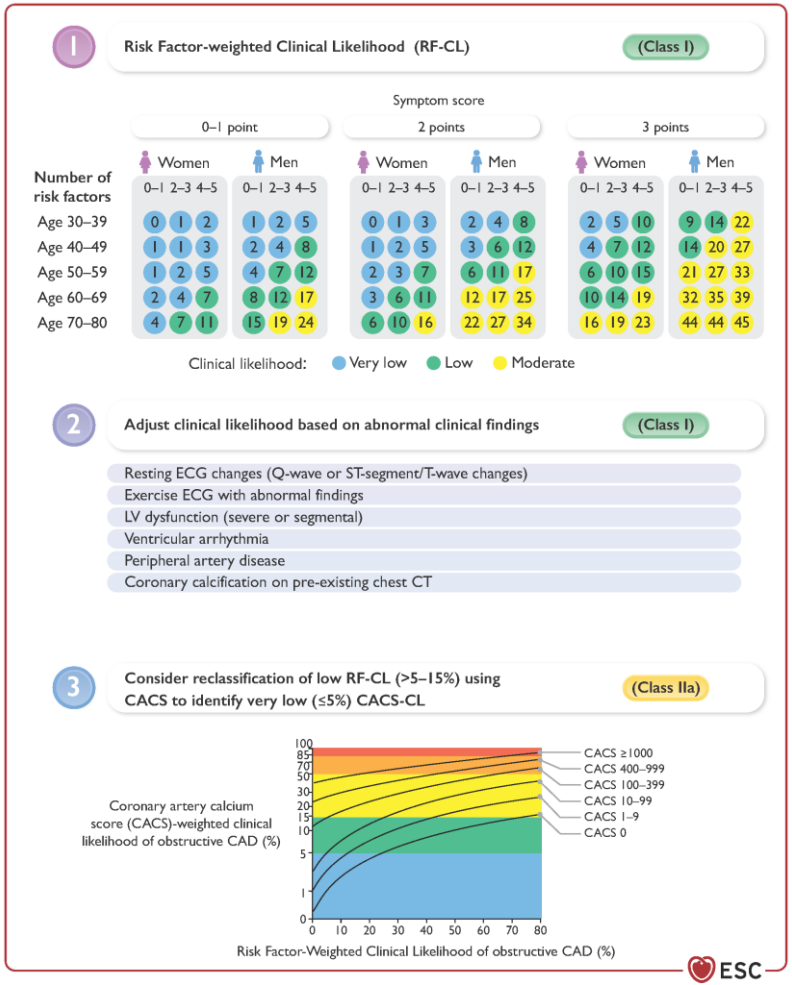
Figure 5

Adjustment and reclassification of the estimated clinical likelihood of obstructive CAD



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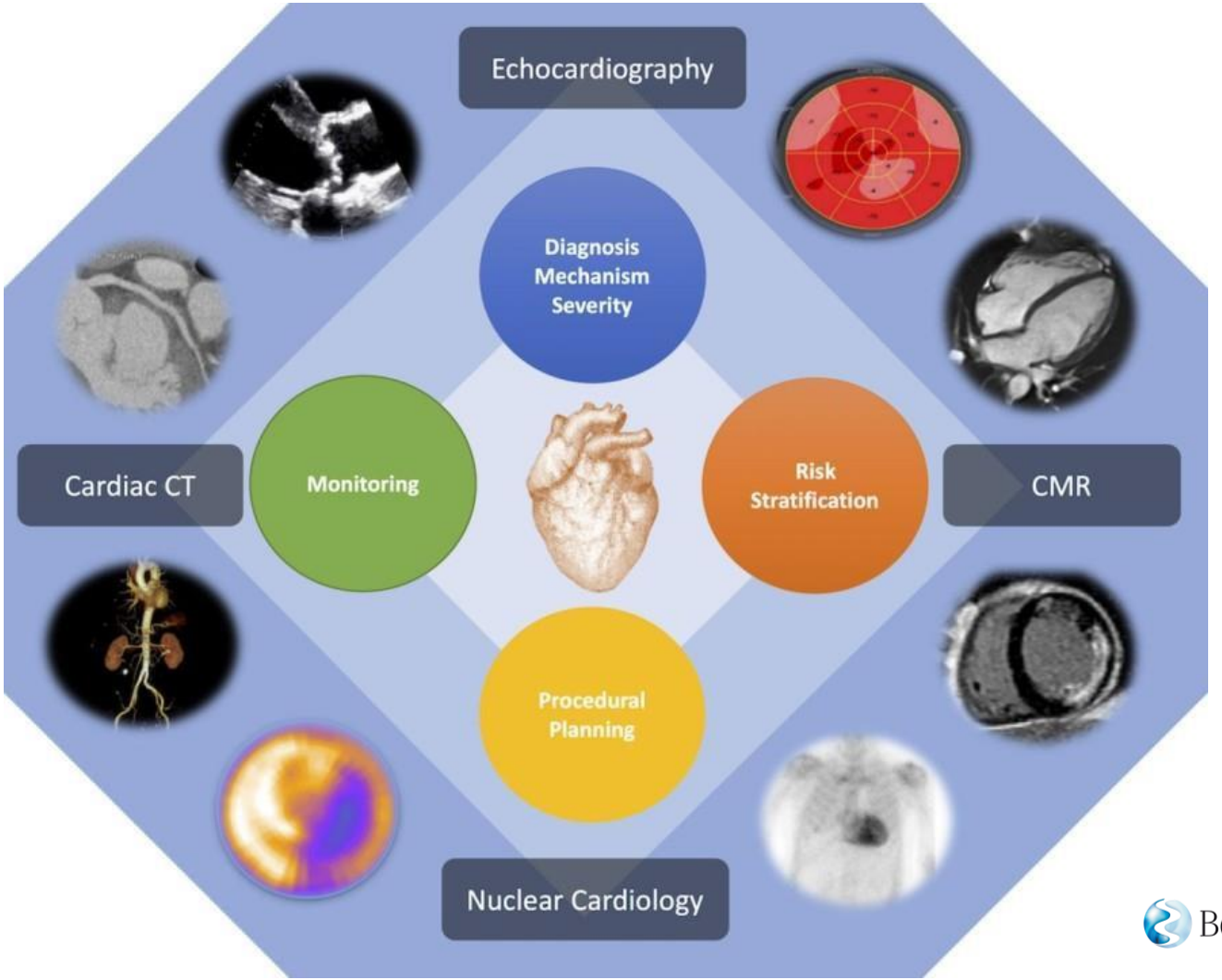

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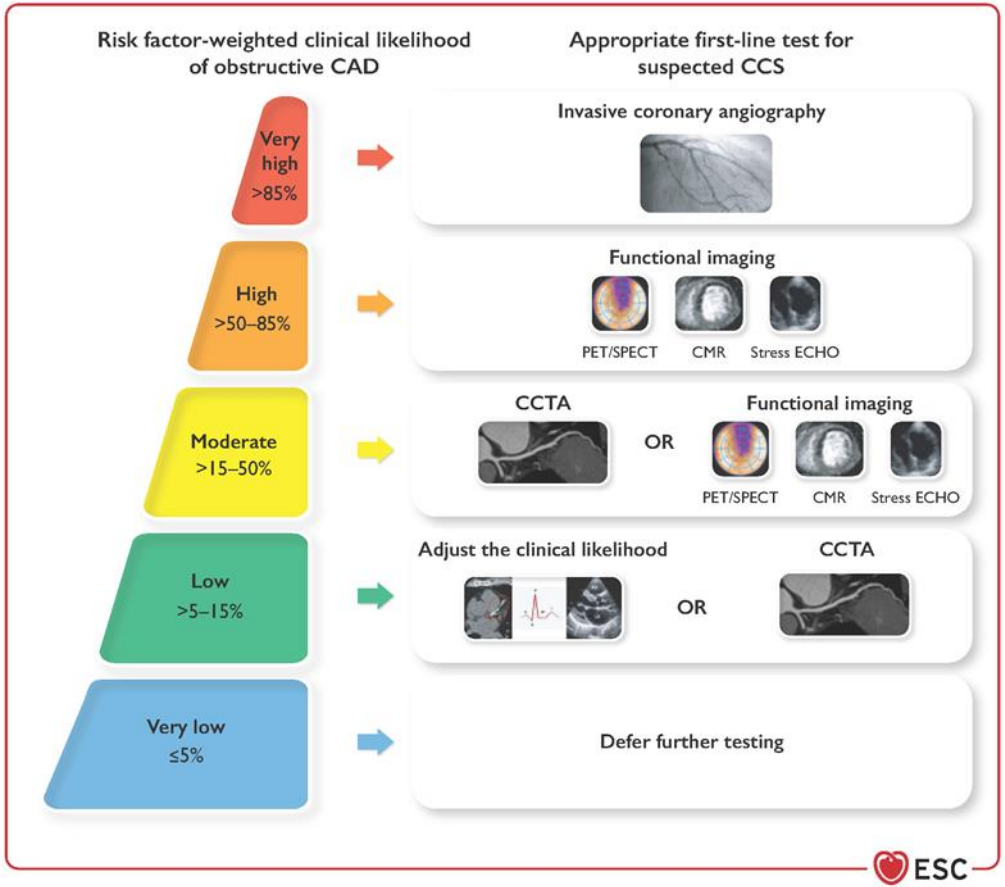
Figure 6

Appropriate first-line testing in symptomatic patients with suspected CCS



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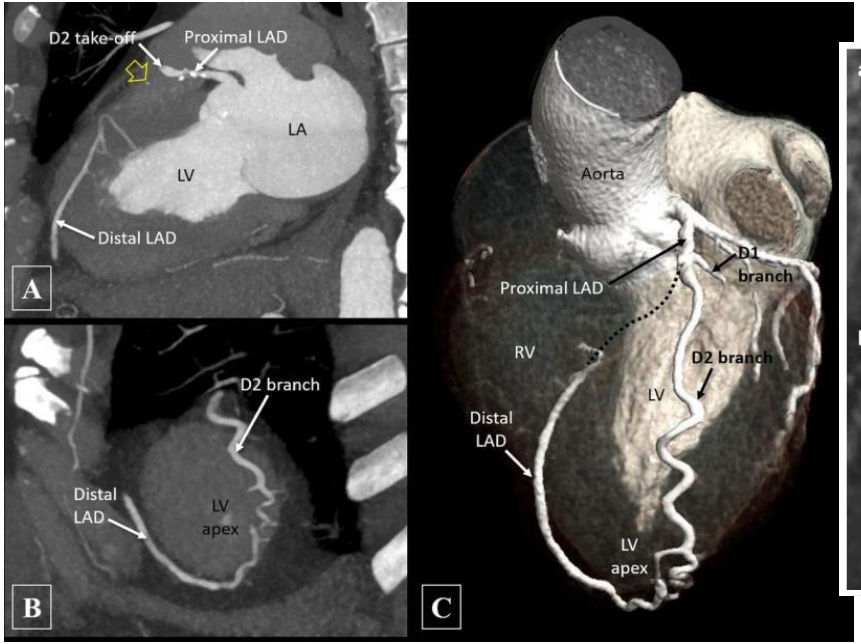
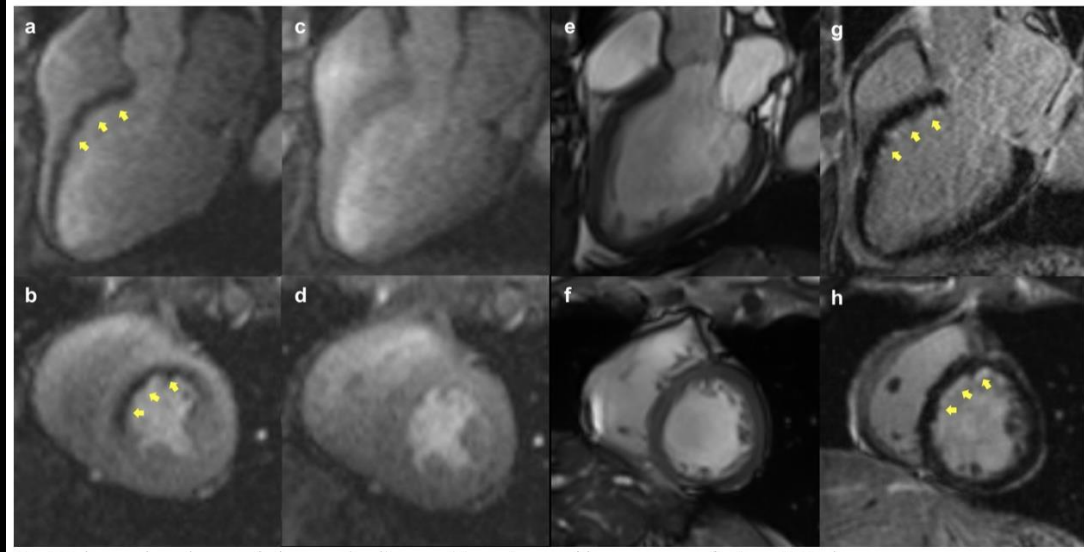
Non-Invasive Testing - CT & MRI





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New Recommendations

Recommendations	Class	Level
Selection of individual diagnostic tests in individuals with suspected chronic coronary syndrome		
To rule out obstructive CAD in individuals with low or moderate (>5%–50%) pre-test likelihood, CCTA is recommended as the preferred diagnostic modality.	I	B
CCTA is recommended in individuals with low or moderate (>5%–50%) pre-test likelihood of obstructive CAD if functional imaging for myocardial ischaemia is not diagnostic.	I	B
Invasive coronary angiography with the availability of invasive functional assessment is recommended to confirm or exclude the diagnosis of obstructive CAD or ANOCA/INOCA in individuals with an uncertain diagnosis on non-invasive testing.	I	B
In patients with a known intermediate coronary artery stenosis in a proximal or mid coronary segment on CCTA, CT-based FFR may be considered.	IIb	B

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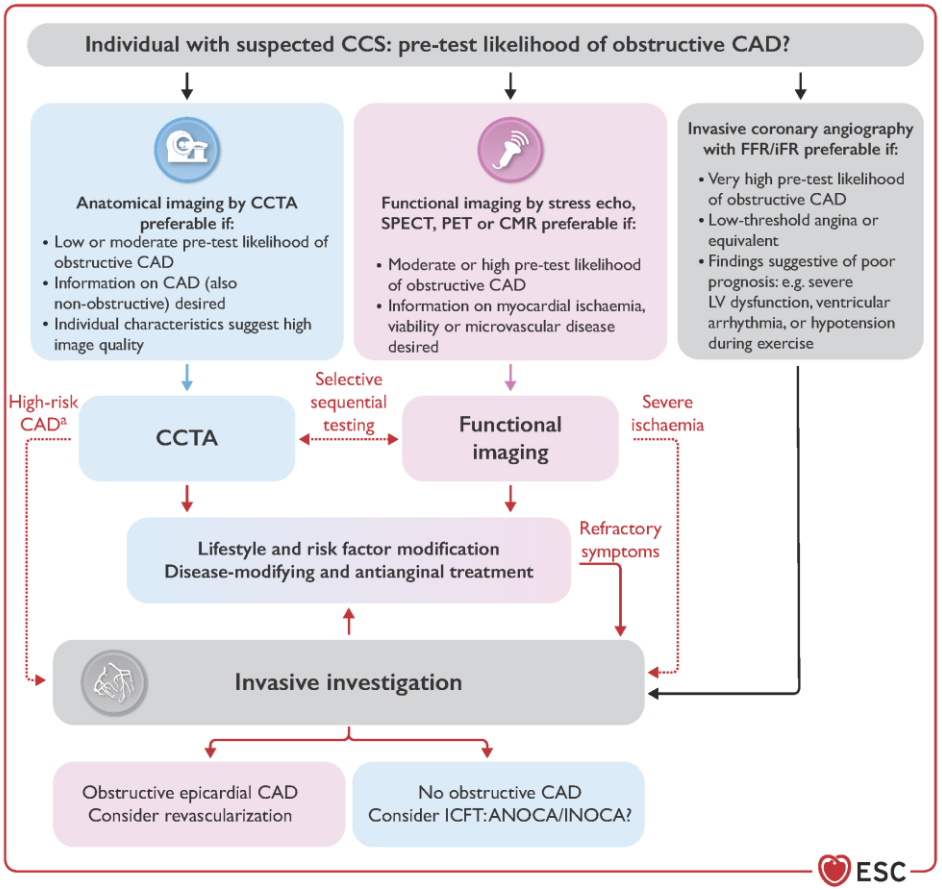
Figure 7

Initial management of symptomatic patients with suspected CCS



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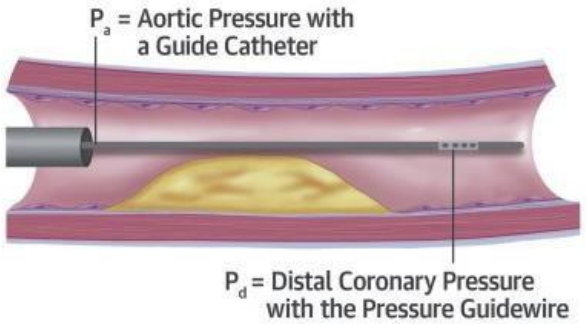
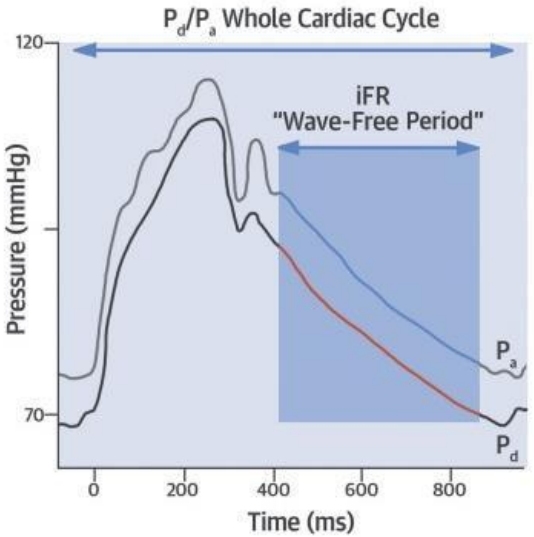
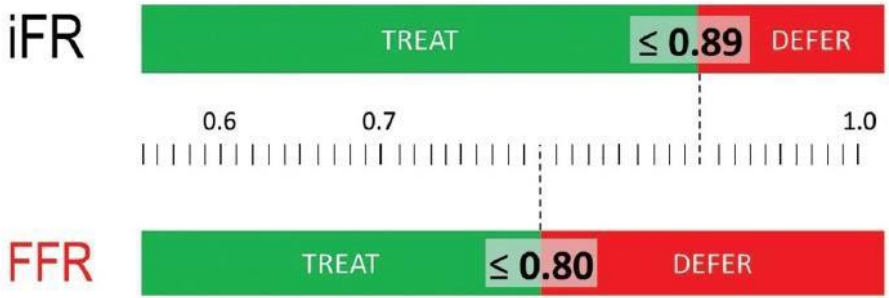
Functional Assessment – Intermediate Lesions

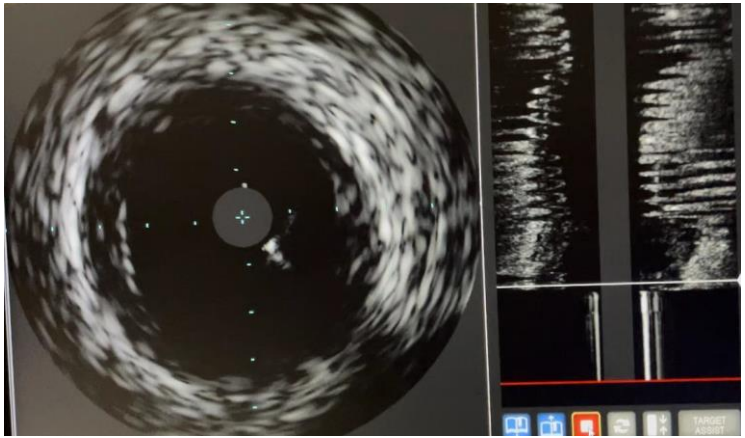
- FFR – Fractional Flow Reserve
- iFR – Instantaneous wave free ratio

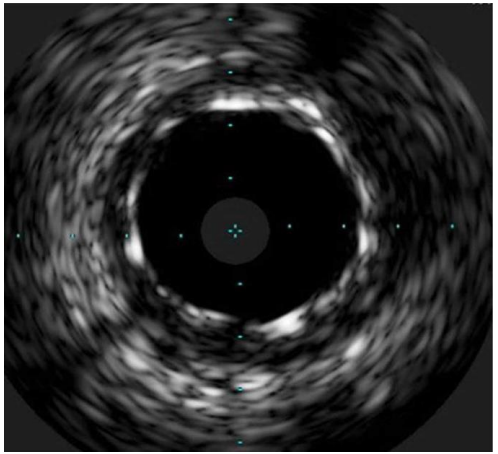


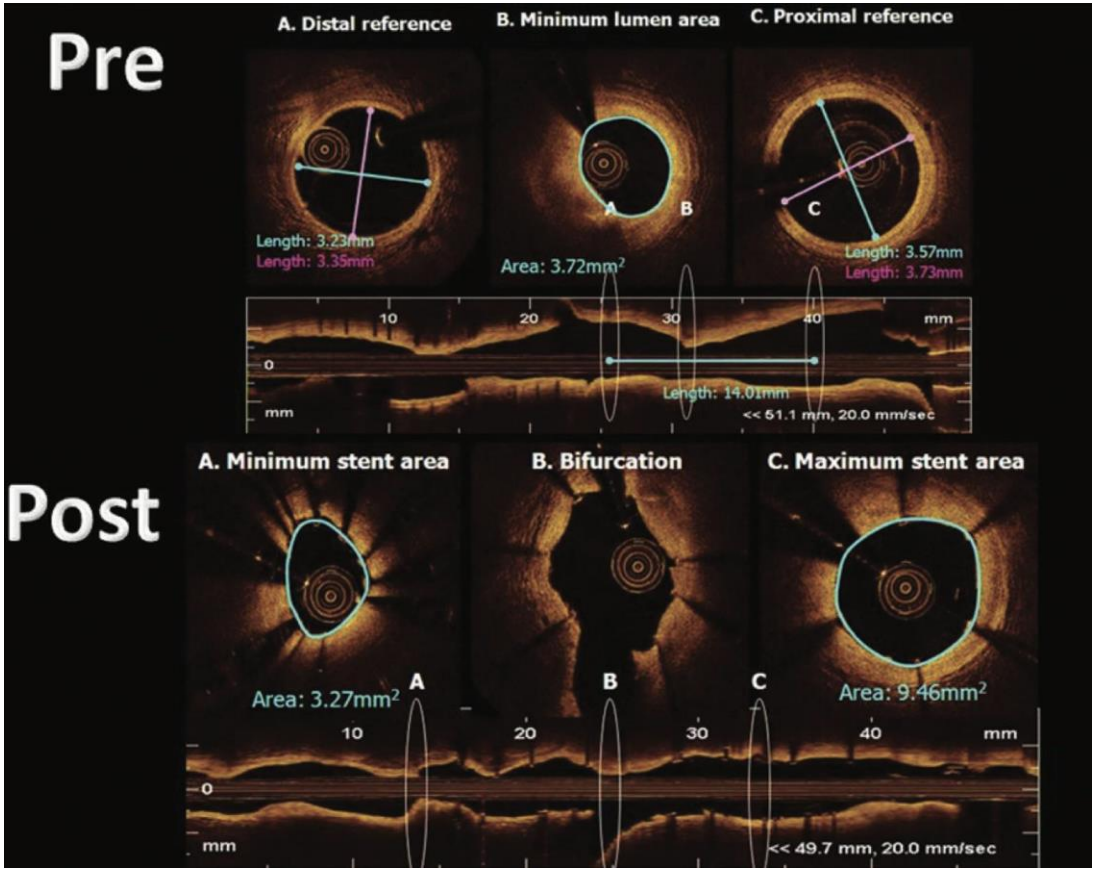




Intra-coronary Imaging







New Recommendations

Recommendations	Class	Level
Assessment of procedural risks and post -procedural outcomes		
Intracoronary imaging guidance by IVUS or OCT is recommended when performing PCI on anatomically complex lesions, in particular left main stem, true bifurcations, and long lesions.	I	A
Intracoronary pressure measurement (FFR or iFR) or computation (QFR):		
• is recommended to guide lesion selection for intervention in patients with multivessel disease;	I	A
• should be considered at the end of the procedure to identify patients at high risk of persistent angina and subsequent clinical events;	IIa	B
• may be considered at the end of the procedure to identify lesions potentially amenable to treatment with additional PCI.	IIb	B
Choice of revascularization modality		
It is recommended that physicians select the most appropriate revascularization modality based on patient profile, coronary anatomy, procedural factors, LVEF, patient preferences, and outcome expectations.	I	C

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Figure 9

Possible combinations of antianginal drugs

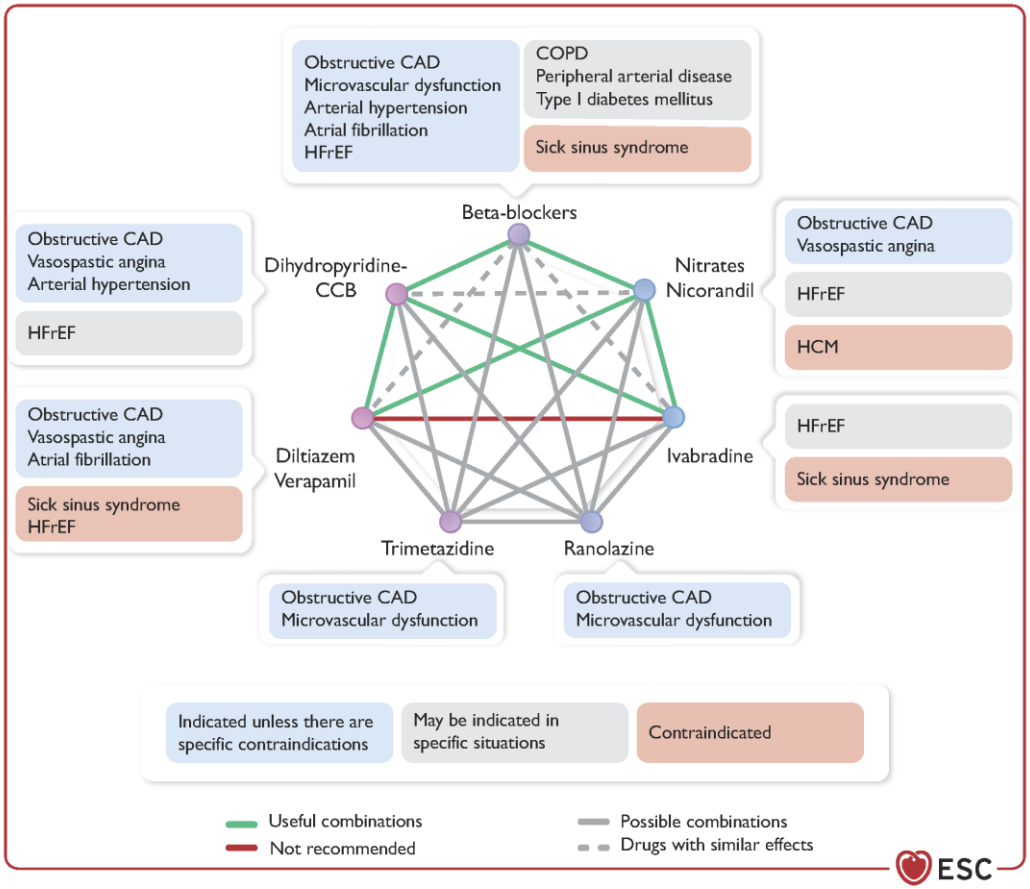

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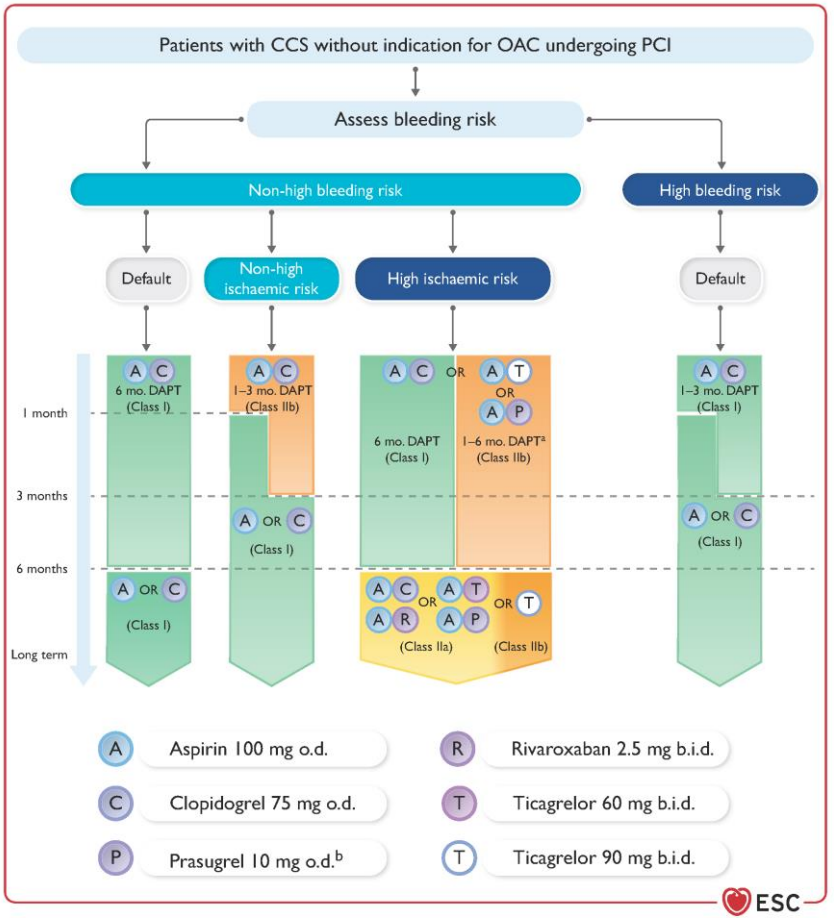
Figure 11

Antithrombotic treatment in CCS patients undergoing PCI



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Revised Recommendations

2019 Guidelines	Class	Level	2024 Guidelines	Class	Level
Antithrombotic therapy post-percutaneous coronary intervention in chronic coronary syndrome patients and an indication for oral anticoagulation					
After uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of dual therapy with an OAC and clopidogrel should be considered if the risk of stent thrombosis is low, or if concerns about bleeding risk prevail over concerns about the risk of stent thrombosis, irrespective of the type of stent used.	**IIa**	**B**	After uncomplicated PCI in CCS patients with concomitant indication for OAC: • early cessation of aspirin (≤1 week); • followed by continuation of OAC and clopidogrel: ○ up to 6 months in patients not at high ischaemic risk or ○ up to 12 months in patients at high ischaemic risk; • followed by OAC alone; is recommended.	**I**	**A**

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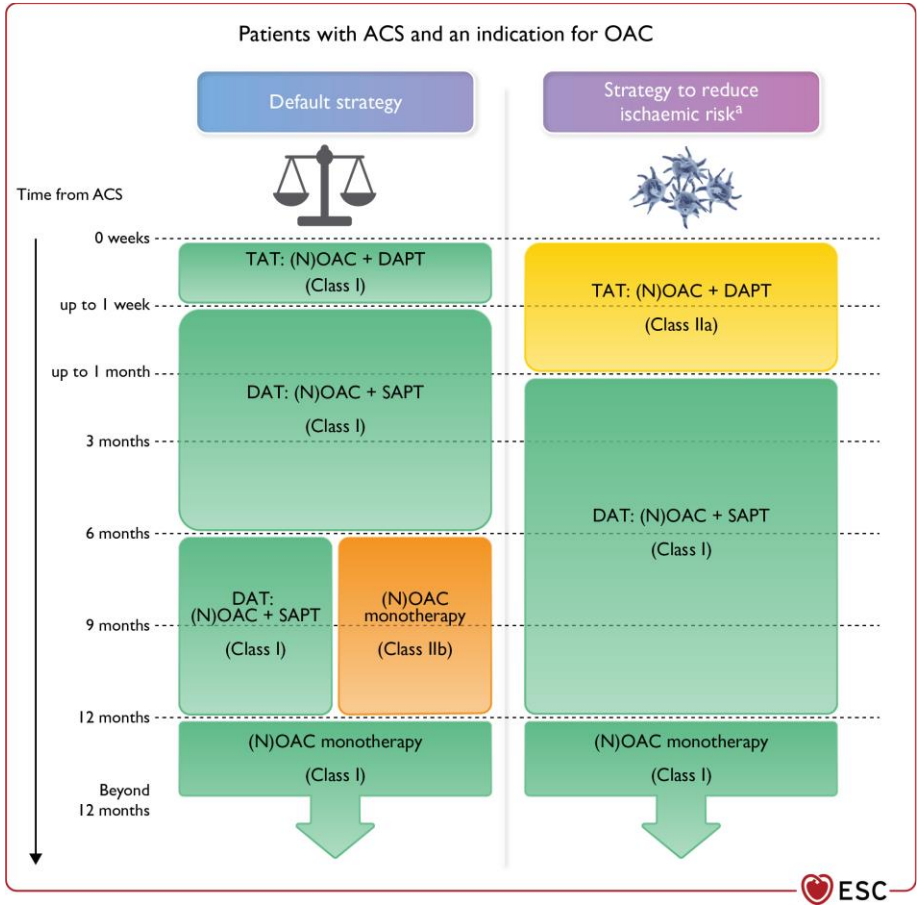
Figure 12

Antithrombotic regimens in patients with acute coronary syndrome and an indication for oral anticoagulation



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New Recommendations

Recommendations	Class	Level
Lipid-lowering drugs in patients with chronic coronary syndrome		
Lipid-lowering treatment with an LDL-C goal of <1.4 mmol/L (55 mg/dL) and a ≥50% reduction in LDL-C vs. baseline is recommended.	I	A
For patients who are statin intolerant and do not achieve their goal on ezetimibe, combination with bempedoic acid is recommended.	I	B
For patients who do not achieve their goal on a maximum tolerated dose of statin and ezetimibe, combination with bempedoic acid should be considered.	IIa	C

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Figure 12

Prevalence of disease characteristics in patients with ANOCA/INOCA referred for invasive coronary functional testing

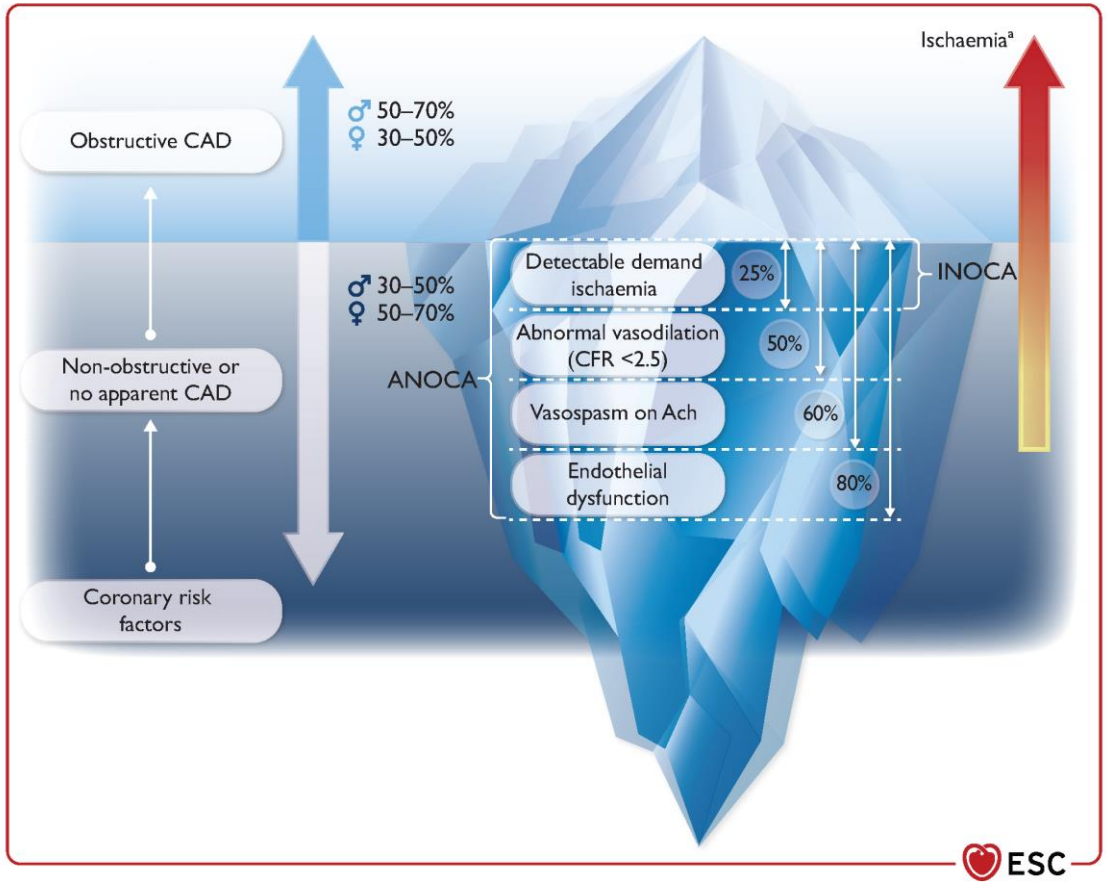

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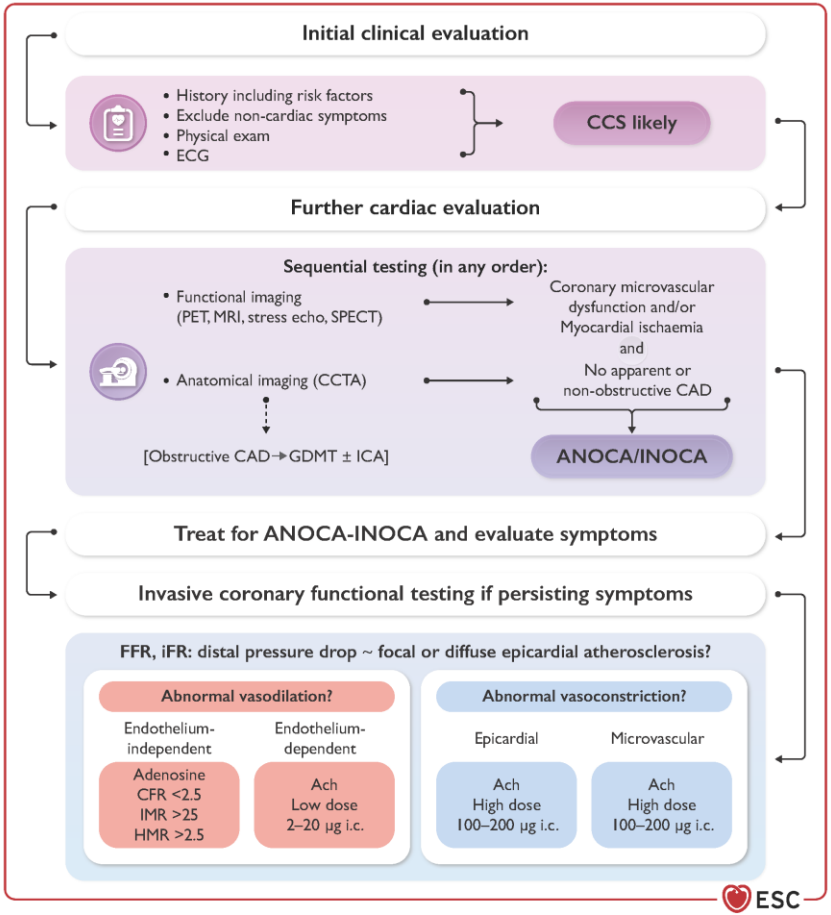
Figure 13

Diagnostic algorithm for patients with angina / ischaemia with non-obstructive coronary arteries



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New Recommendations

Recommendations	Class	Level
Recurrent or refractory angina/ischaemia		
In patients with refractory angina leading to poor quality of life and with documented or suspected ANOCA/INOCA, invasive coronary functional testing is recommended to define ANOCA/INOCA endotypes and appropriate treatment, considering patient choices and preferences.	I	B

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Figure 15

Treatment of angina / ischaemia with non-obstructive coronary arteries

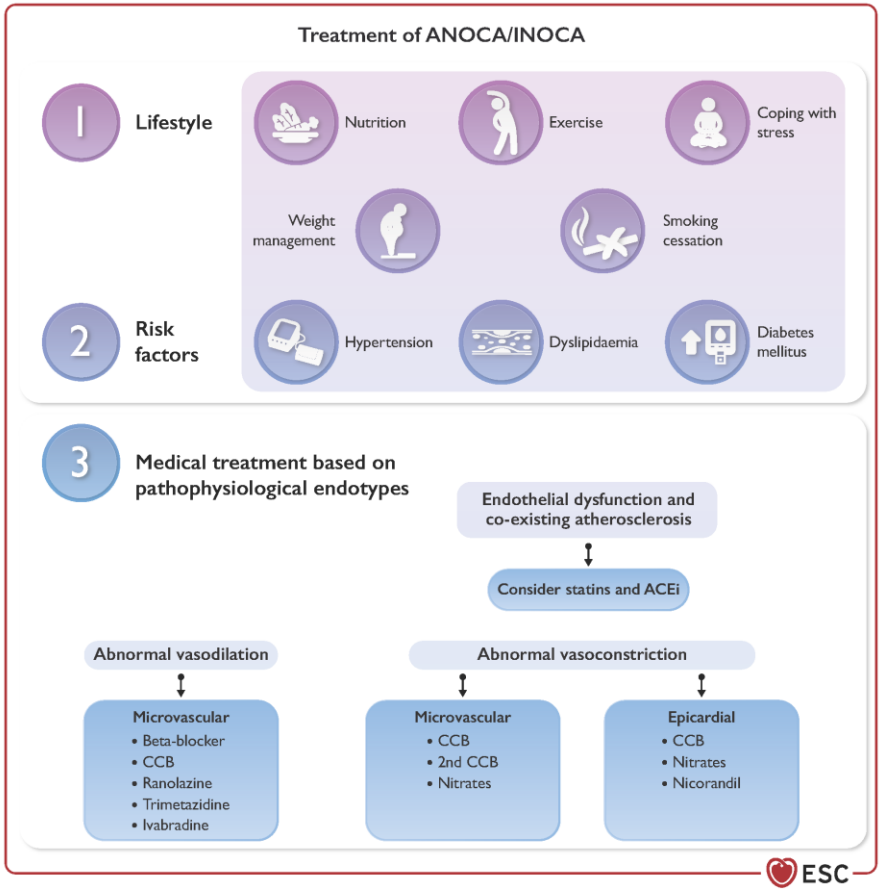

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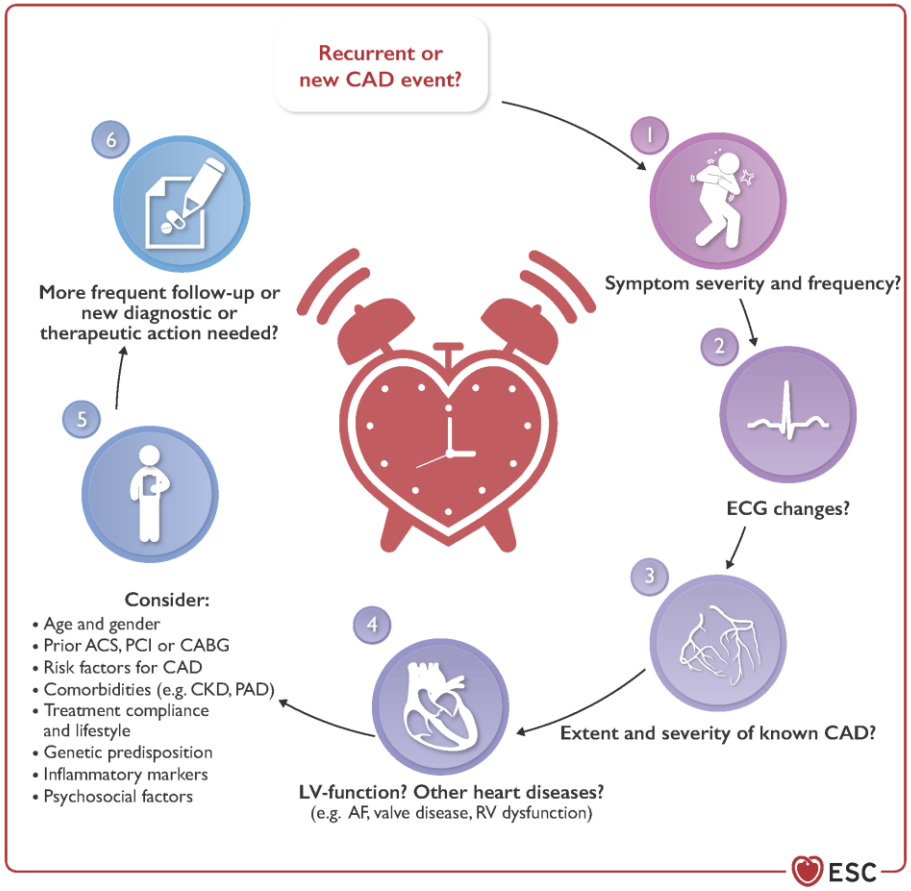
Figure 18

Approach for the follow-up of patients with established CCS



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Thank You

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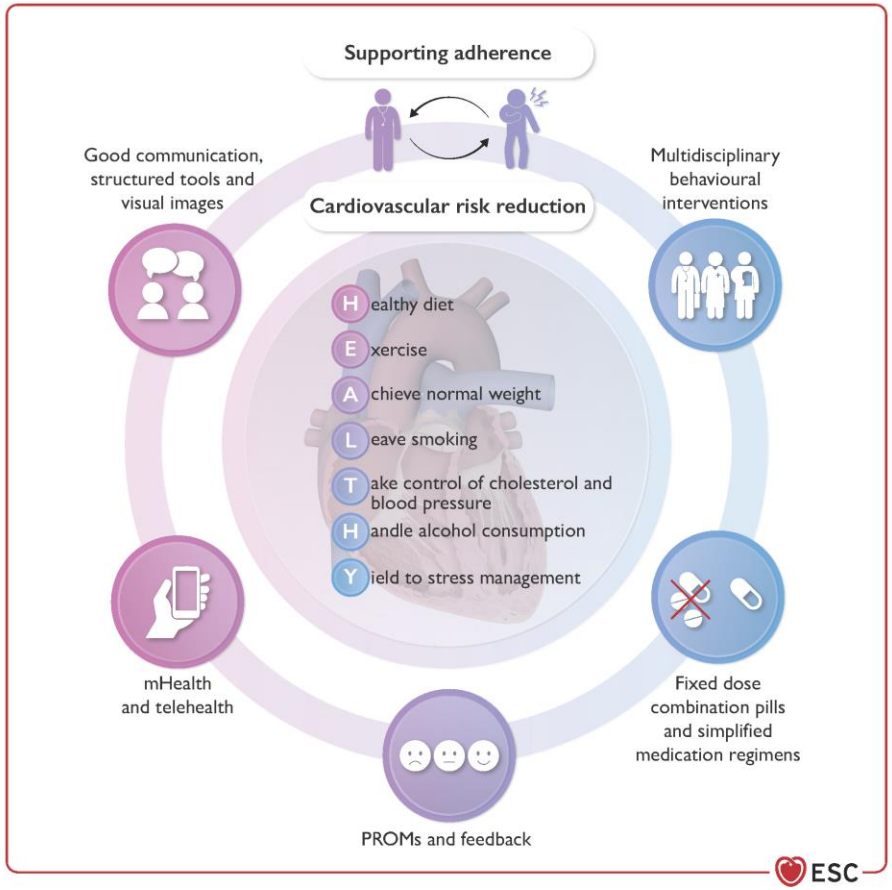
Figure 17

Strategies for long-term adherence to a healthy lifestyle



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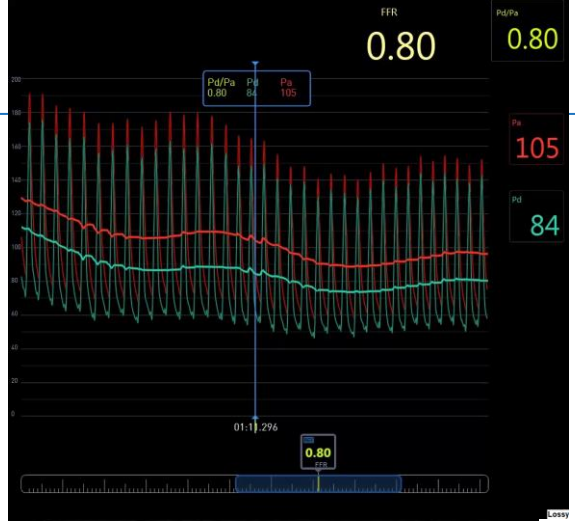
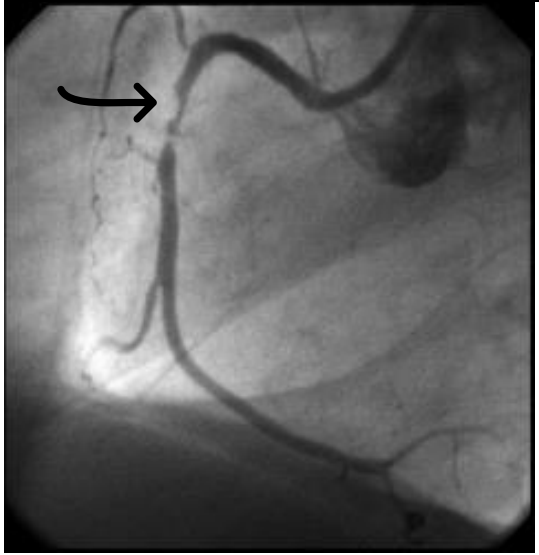
Invasive Testing

- Coronary angiogram 1st line test with High clinical likelihood/Severe symptoms and those with typical angina at low levels of exercise
- Otherwise reserved for those with abnormal non- invasive testing





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