

# 5<sup>TH</sup> UMBRELLA

FOCUSED CARDIOLOGY FORUMS

## THE ART OF **ANTITHROMBOTIC THERAPY**

IN DAILY CARDIOVASCULAR PRACTICE

### 1<sup>st</sup> Panel

## Antithrombotic therapy in ACS

Panelist Experts

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# Learning Objectives

- Fibrinolysis in STEMI
  - Which ACS patients are candidates for fibrinolysis?
  - How to choose between agents?
  - Dosing & dose adjustment?
  - When is fibrinolysis considered failed?
- Aspirin in ACS
  - Which patients?
  - Loading & maintenance dose & dose adjustments?
  - Timing of administration?
  - Duration of use?

## Learning Objectives (cont.)

- P2Y12 Inhibitors in Different ACS Scenarios  
(STEMI candidates for fibrinolytic/PPCI & NSTEMI-ACS candidates for immediate/early or selective invasive strategy)
  - Which patients?
  - Loading & maintenance dose & dose adjustments?
  - Timing of administration? Pretreatment rules?
  - Duration of use?
  - How to choose between agents?
  - Escalation & de-escalation rules?

(Continued)

## Learning Objectives (cont.)

- How to decide on the number of antiplatelets after ACS? (DAPT vs. monotherapy, agents, and doses)
- How to measure & balance thrombotic vs. bleeding risk?
- When to add PPI to the regimen?
- Role of GP IIb/IIIa inhibitors in ACS patients?
- Anticoagulants in ACS (STEMI & NSTEMI-ACS)
  - Which agent?
  - Timing of administration?
  - Duration of treatment?
  - Dose adjustments?

## Case Vignette 1:

- A 72-year-old lady with a history of hypertension and type 2 diabetes. No known previous history of ischemic heart disease. Otherwise, her past medical history is unremarkable. She presented to the ED with crushing chest pain and diaphoresis that occurred about 2 hours ago, lasting approximately 20 minutes, and was relieved by 2 sublingual NTG at home. She now has only mild chest discomfort.
  - BP: 130/82 mmHg (right arm), 132/84 mmHg (left arm)
  - HR: 84 bpm
  - SaO<sub>2</sub>: 94% on room air
  - Heart: Unremarkable
  - Lungs: Clear
  - BMI: 23

## Case Vignette 1 (cont.) :

- Drug History:
  - Oral agents for diabetes
  - Amlodipine/Valsartan for hypertension
  - Statin
- ECG:
  - Normal sinus rhythm, no conduction blocks
  - ST elevation (1.5 mm) in V1–V3
- The hospital is in a small town without PCI capability. The nearest PCI-capable hospital is about 3 hours away, pending acceptance for transfer.

## Question Case 1:

What is your reperfusion strategy and antithrombotic therapy in this setting?

- Acute phase
- In-hospital course
- Long-term management

## Case Vignette 2:

- As the on-call cardiologist, you receive a call from your ED colleague at 7 PM regarding a patient who presented with chest pain.
- Patient: 54-year-old gentleman, current cigarette smoker
- Past Medical History & Medications: No known history of chronic illnesses or medications
- Presentation:
  - Two days of frequent chest pain that has progressively intensified
  - The most recent episode occurred about 2 hours ago and lasted approximately 10 minutes
  - Currently symptom-free

## Case Vignette 2 (cont.) :

- Vitals: Stable
- Physical Exam: No signs of heart failure
- ECG at Presentation: Sinus rhythm with ~1 mm of horizontal ST depression in V4–V6
- Repeat ECG: No dynamic ST/T changes
- hs-cTnl: Markedly elevated
- Bedside TTE: Preserved LVEF
- Hospital Capabilities: PCI-capable, but cath lab is closed overnight and resumes routine operations at ~8 AM

## Question Case 2:

What is your recommendation regarding reperfusion strategy, anticipated antithrombotic therapy in the ED, hospital course, and discharge management?

# PANEL DISCUSSION

Stay tuned for the 5th Umbrella

<https://B2n.ir/Umbrella5th>

