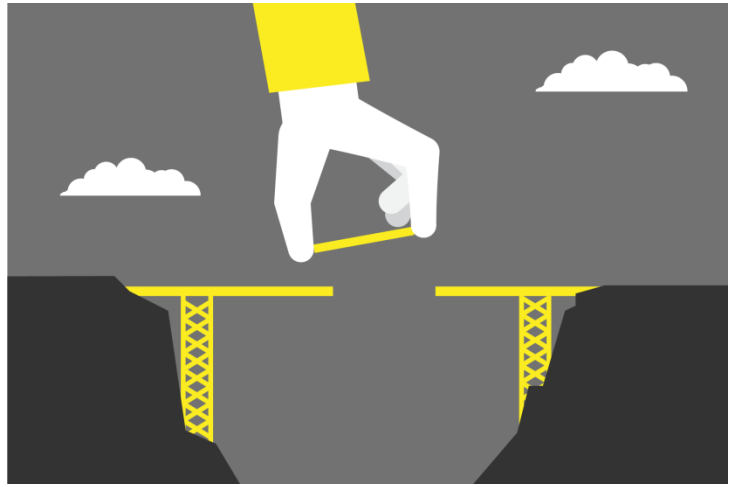
Hội chứng vành mạn:
Có thể lấp đầy những khoảng trống?

PGS. TS. BS. Trương Quang Bình

ĐHYD TP. HCM



Hành trình BN đau thắt ngực
Những khoảng trống còn để ngỏ…

Trước chẩn đoán

Từ 3 tuần - > 3 tháng

Không được nhận biết là đau thắt ngực[2] 30%

1. JC. Will et al. Circ Cardiovasc Qual Outcomes. 2014 May;7(3):407-13; 2. Kureshi F. et al. Clin Cardiol. 2017;40(1):6-10; 3. Circ Cardiovasc Qual Outcomes. 2016 Sep;9(5):554-9.;
4. Qintar M. et al. Eur Heart J Qual Care Clin Outcomes. 2016;2(3):208-214

Điều trị chưa tối ưu

3. Circ Cardiovasc Qual Outcomes. 2016 Sep;9(5):554-9.;

Khuyến cáo ESC 2019 – Lấy BN làm trung tâm

Optimal Treatment

- Treatment that satisfactorily controls symptoms and prevents cardiac events.

- With **maximal patient adherence** and **minimal adverse events.**

Aims of Pharmacological Management

- Reduce **angina symptoms** and **exercise-induced ischaemia**.

- Prevent cardiovascular events.

Event prevention

- Lifestyle management
- Control of risk factors

+ Educate the patient

- Aspirine[b]
- Statins
- Consider ACEI or ARBs

LOR = I

LOE = A

Angina relief

1st line

Short-acting Nitrates, *plus*

- **Beta-blockers** *or* **CCB-heart rate** ↓
- Consider **CCB-DHP** *if* low heart rate or intolerance/contraindications
- Consider **Beta-blockers + CCB-DHP** *if* CCS Angina > 2

2nd line

May add or switch (1st line for some cases)

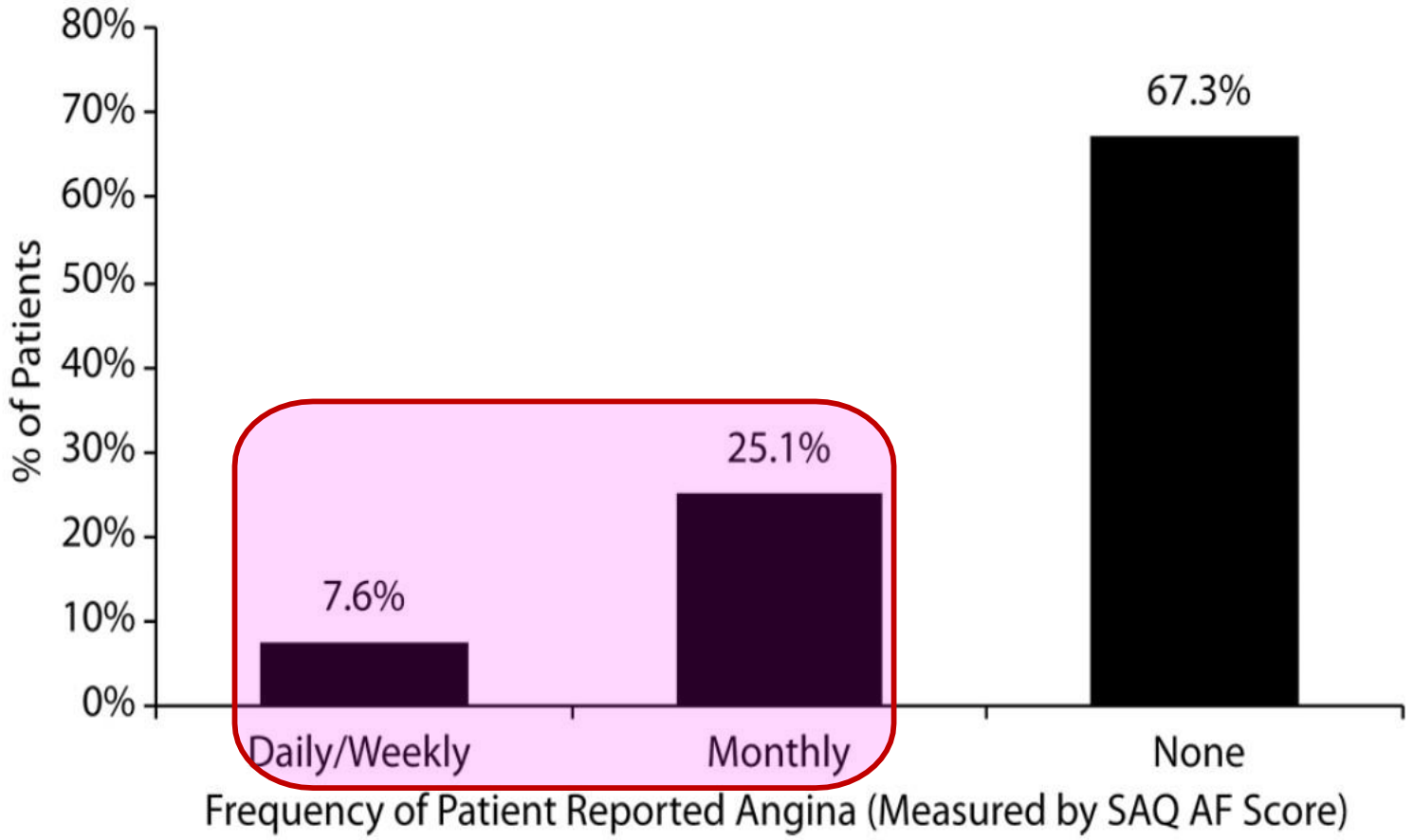
Ivabradine
Long-acting nitrates
Nicorandil
Ranolazine[a]
Trimetazidine[a]

ESC Highlights 2019

2013

Vẫn còn triệu chứng 43%

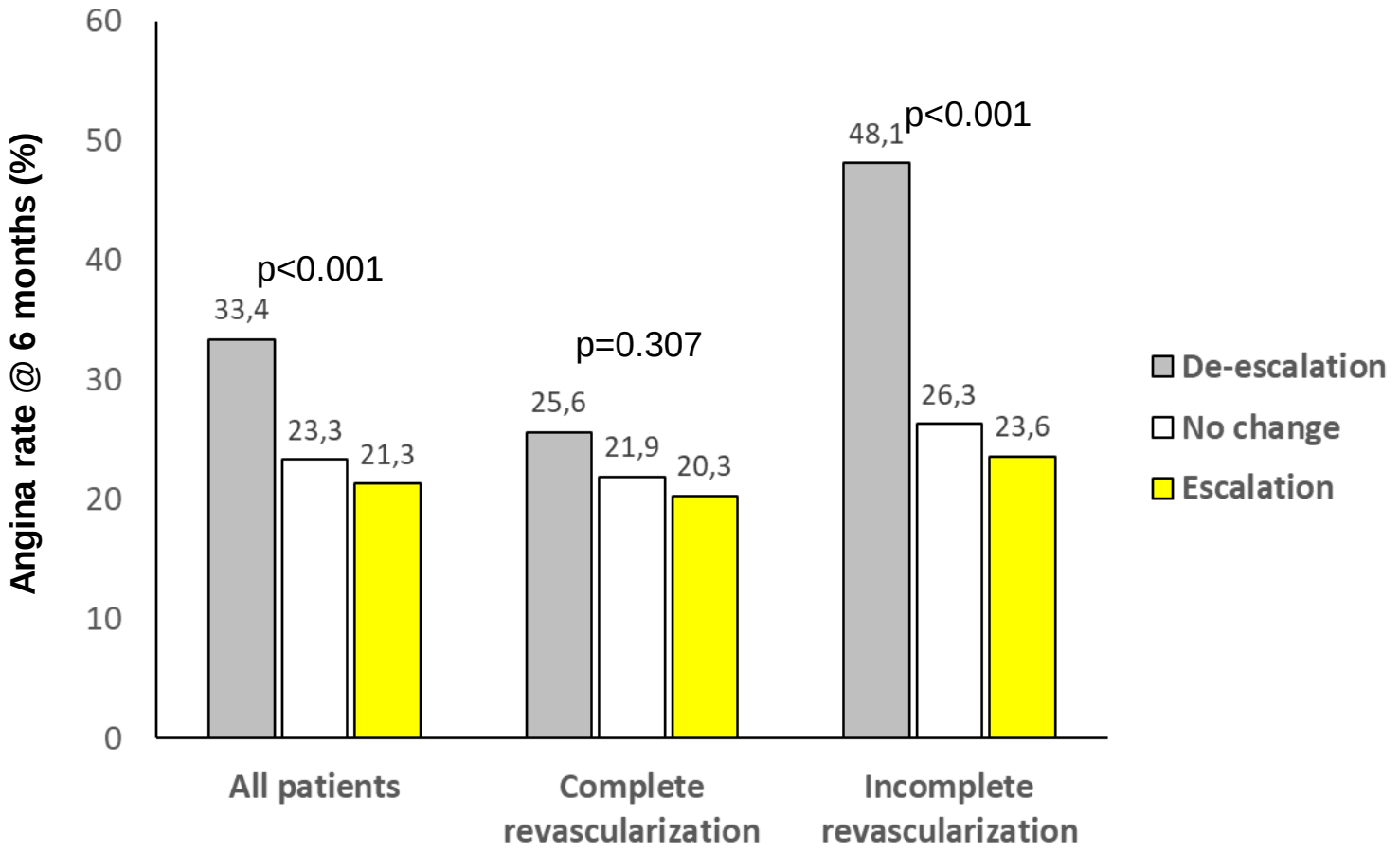
More than 30 % of patients with stable angina continue experiencing symptoms despite medical treatment



[The prevalence and management of angina among patients with chronic coronary artery disease across US outpatient cardiology practices: insights from the Angina Prevalence and Provider Evaluation of Angina Relief (APPEAR) study Faraz Kureshi Clin Cardiol 2017; 40(1):6–10]

Impact of De-Escalation of Antianginal Medications on Health Status After PCI

2743 PCI patients enrolled in a 10-center PCI Registry

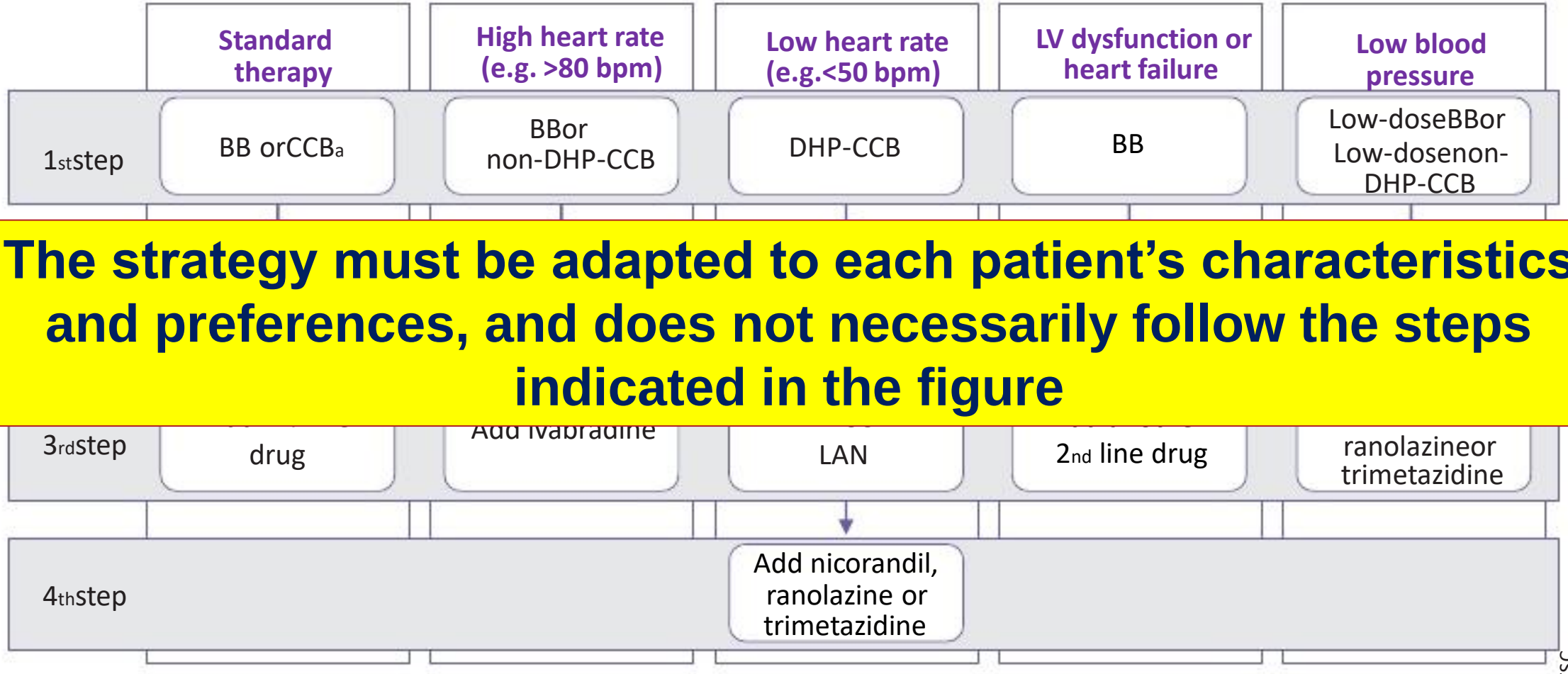


Antianginal medications (AAM) de-escalation was defined as fewer AAMs at discharge versus admission or >25% absolute dose decrease

Qintar M, et al. J Am Heart Assoc. 2017;6:e006405

Chiến lược điều trị lâu dài các thuốc chống thiếu máu cơ tim: CÁ THỂ HÓA

ESC European Society of Cardiology



The strategy must be adapted to each patient's characteristics and preferences, and does not necessarily follow the steps indicated in the figure

[a] Combination of a BB with a DHP-CCB should be considered as first step; combination of a BB or a CCB with a second-line drug may be considered as a first step.

Những vấn đề còn bỏ ngỏ/bàn cãi: khoảng trống của bằng chứng

10. Gaps in the evidence .....

10.1 Diagnosis and assessment .....

10.2 Assessment of risk .....

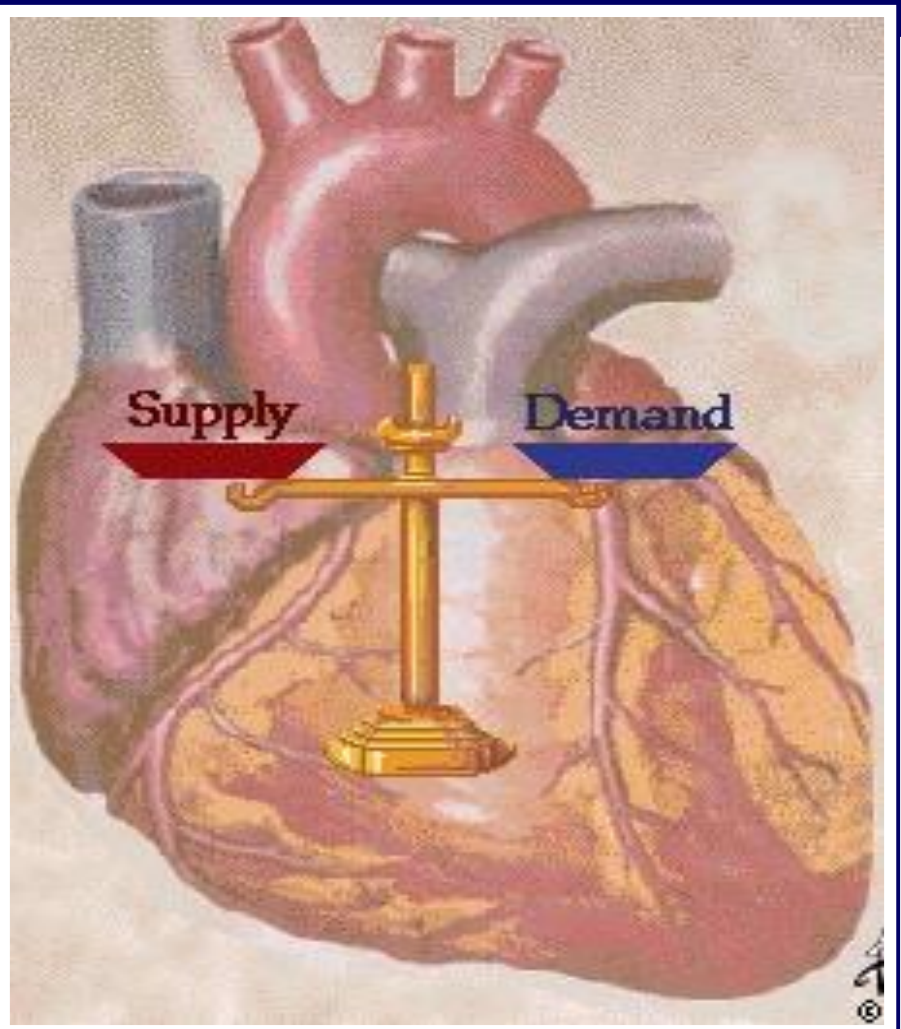
10.3 Lifestyle management .....

10.4 Pharmacological management .....

Whether the initial use of second-line anti-ischaemic therapy (i.e. long-acting nitrates, ranolazine, nicorandil, ivabradine, or trimetazidine) alone or in combination with a first-line drug (i.e. beta-blocker or CCB) is superior to the combination of a beta-blocker with a CCB to control anginal symptoms and myocardial ischaemia in patients with CCS remains to be proven.

Pathophysiology of Ischemia: Coronary equation

Blood flow



Heart rate

SBP

LVEDV

Wall thickness

Contractility

Myocardial cell metabolism

Incidence of angina patients with elevated HR

Heart Rate and Use of Beta-Blockers in Stable Outpatients with Coronary Artery Disease

Ph. Gabriel Steg[1,2,3]*, Roberto Ferrari[4], Ian Ford[5], Nicola Greenlaw[5], Jean-Claude Tardif[6], Michal Tendera[7], Hélène Abergel[1,2,3], Kim M. Fox[8], for the CLARIFY Investigators[¶]

CLARIFY
ProspeCtive observational LongitudinAl RegIstry oF patients with stable coronary arteriY disease

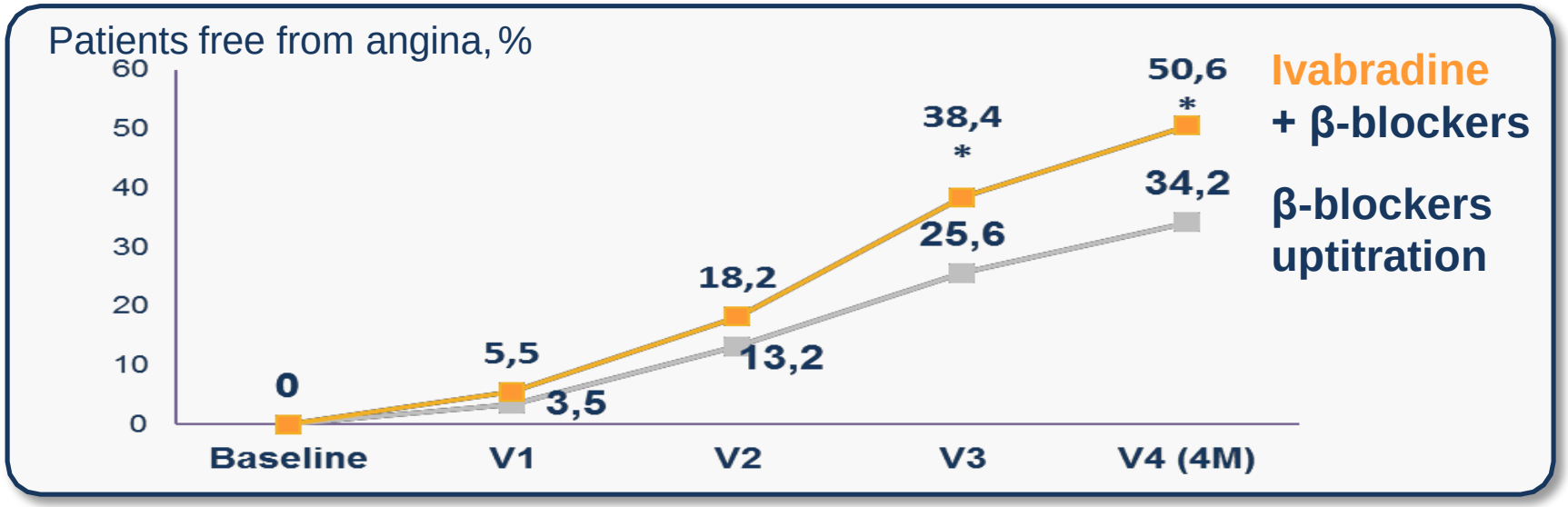
✓ 44% of angina patients present with HR≥70

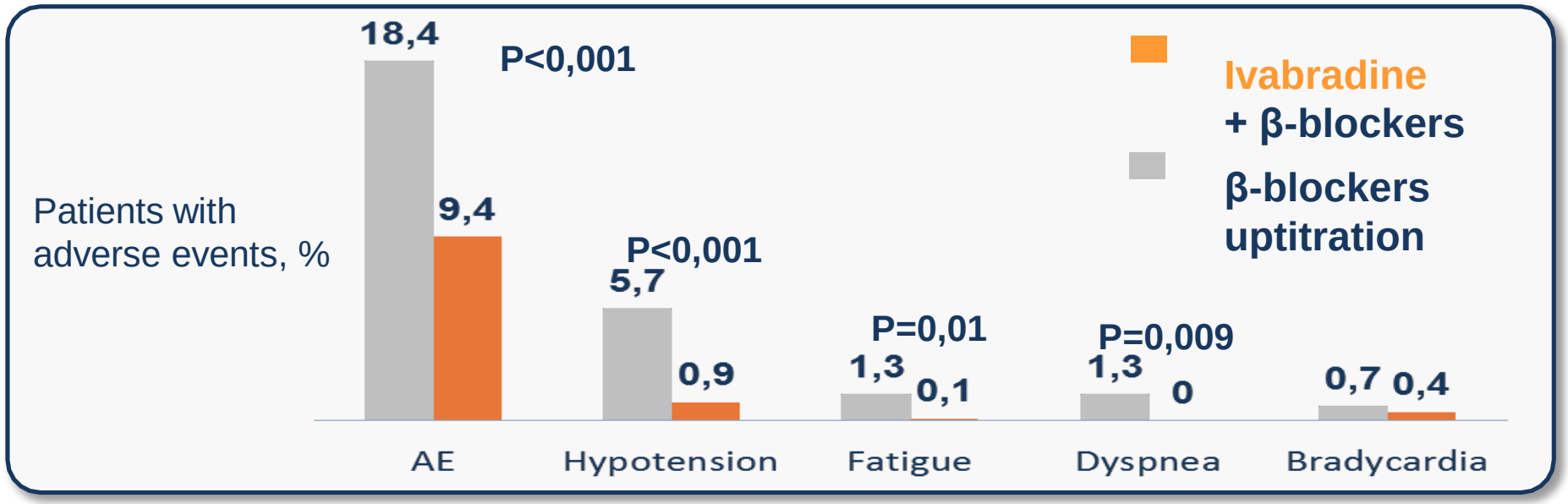
Beta-blockers were used in 75.1% of patients and another 14.4% had intolerance or contraindications to beta-blocker therapy

✓ 41.1% of angina patients on β-blockers had HR≥70 bpm

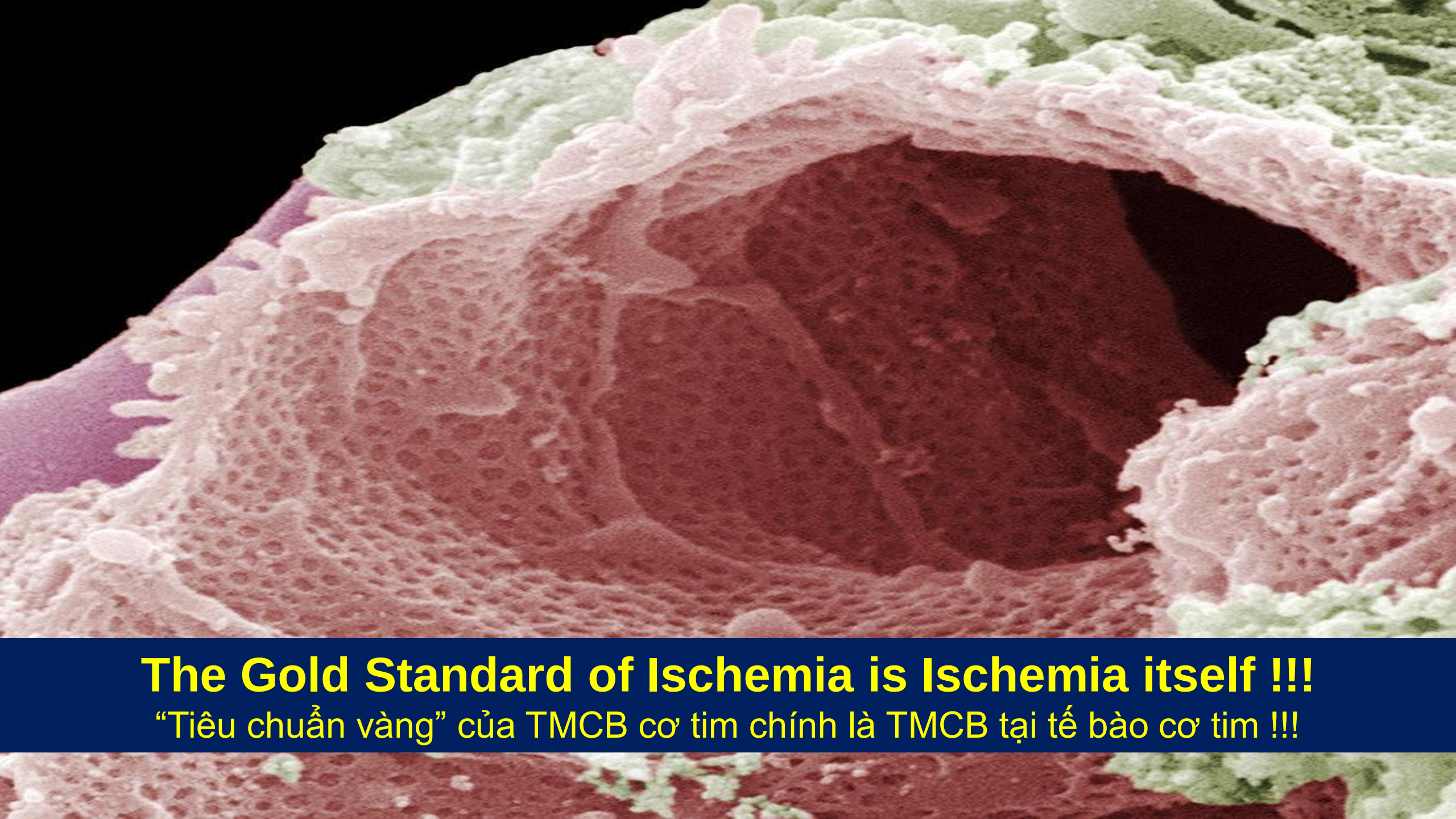
Steg PA et al. JAMA Intern Med. 2014;174:1651-59.

Efficacy of ivabradine/BBs compared to uptitration of BBs in patients with stable angina (CONTROL-2)





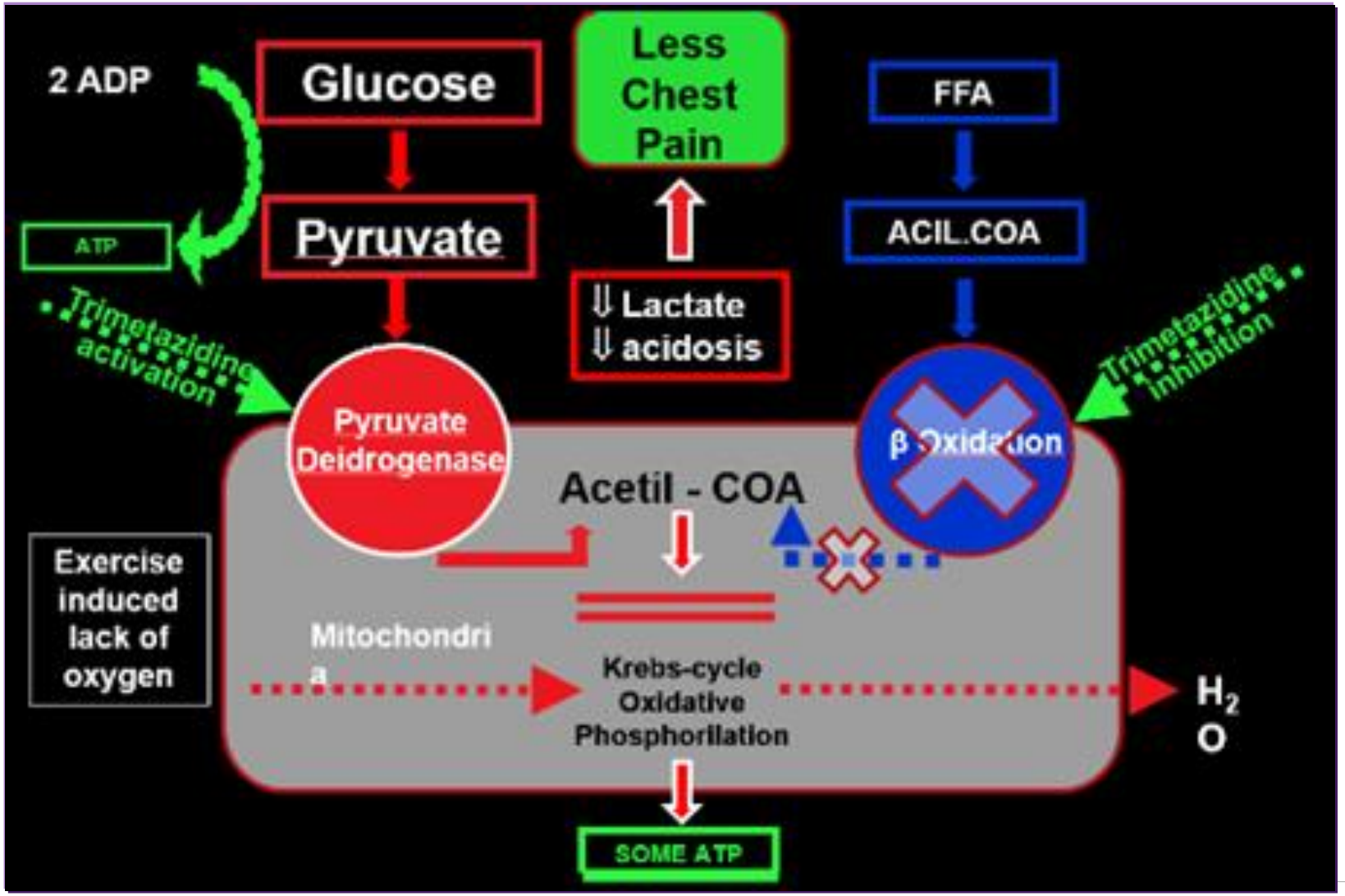
M Glezer, Adv. in Therapy 2018.



The Gold Standard of Ischemia is Ischemia itself !!!

"Tiêu chuẩn vàng" của TMCB cơ tim chính là TMCB tại tế bào cơ tim !!!

Trimetazidine
Tác động trực tiếp tại tế bào cơ tim



Kantor PF et al. Circ Res. 2000;86:580-588

Trimetazidine MR is upgraded from IIb to IIa

European Heart Journal (2013) 34, 2949–3003
doi:10.1093/eurheartj/eht296

ESC GUIDELINES

2013 ESC guidelines on the management of stable coronary artery disease

For second-line treatment, trimetazidine may be considered.	IIb	B

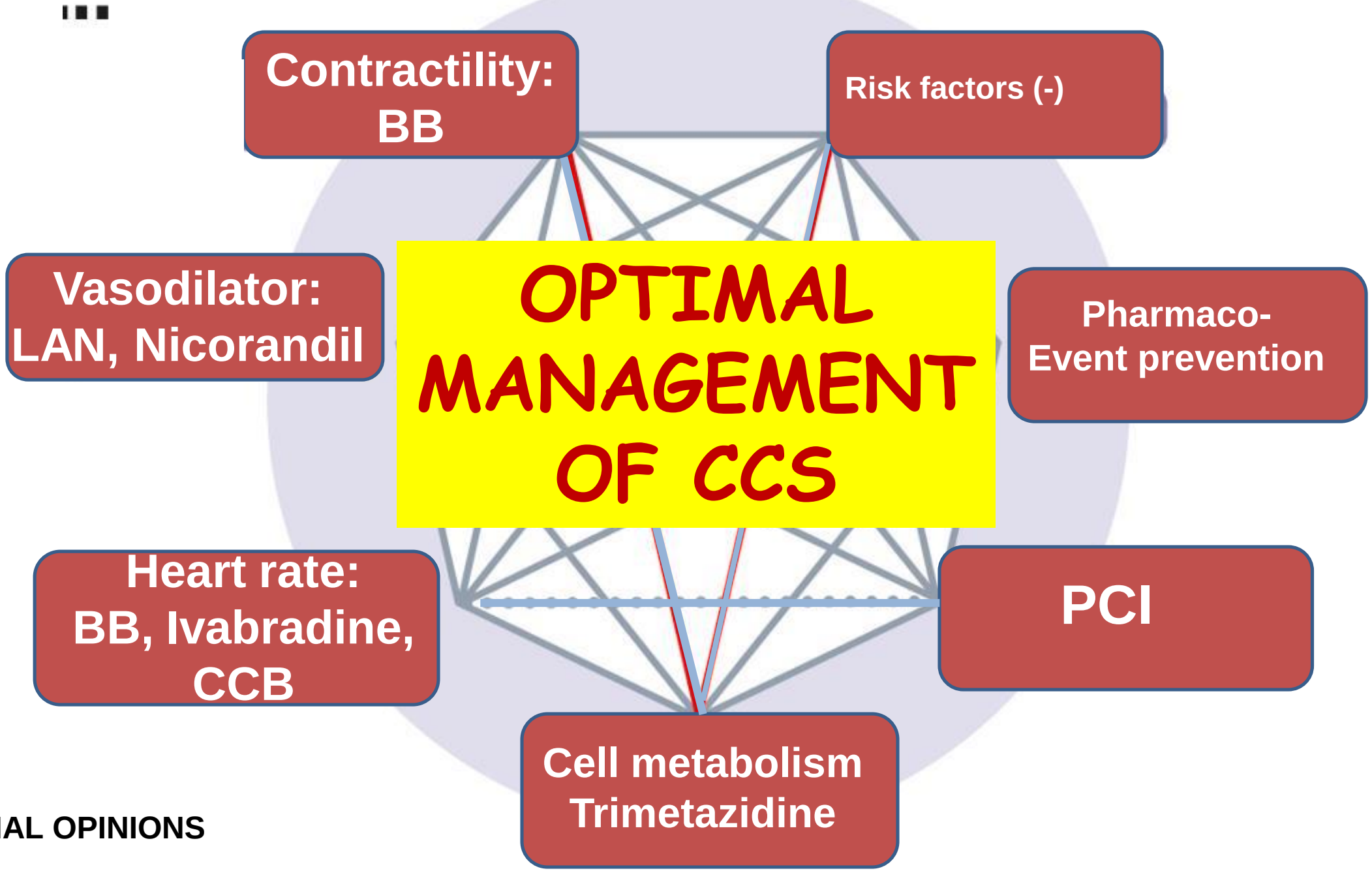
ESC European Society of Cardiology
European Heart Journal (2019) 00, 1–71
doi:10.1093/eurheartj/ehz425

ESC GUIDELINES

2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes

The Task Force for the diagnosis and management of chronic coronary syndromes of the European Society of Cardiology (ESC)

Nicorandil,[241–244,246] ranolazine,[248,265] ivabradine,[235–237] or trimetazidine[252,255] should be considered as a second-line treatment to reduce angina frequency and improve exercise tolerance in subjects who cannot tolerate, have contraindications to, or whose symptoms are not adequately controlled by beta-blockers, CCBs, and long-acting nitrates.	IIa	B
In subjects with baseline low heart rate and low BP, ranolazine or trimetazidine may be considered as a first-line drug to reduce angina frequency and improve exercise tolerance.	IIb	C
In selected patients, the combination of a beta-blocker or a CCB with second-line drugs (ranolazine, nicorandil, ivabradine, and trimetazidine) may be considered for first-line treatment according to heart rate, BP, and tolerance.[198]	IIb	B



PERSONAL OPINIONS

Take home message

- **2 khoảng trống quan trọng:**
  - Tỉ lệ BN chưa được chẩn đoán còn cao
  - **Điều trị chưa tối ưu, Bn còn triệu chứng**

- **Chiến lược:**
  - Lựa chọn thuốc tối ưu cần quan tâm đến **bệnh cảnh lâm sàng đa dạng** của hội chứng mạch vành mạn**.**

- **Chú ý các thuốc:**

Tác động trực tiếp tại tế bào cơ tim, tác động giảm thêm tần số tim, ít tác dụng phụ sẽ giúp tối ưu hóa chất lượng cuộc sống (giảm đau ngực, tăng khả năng gắng sức) cho BN.

Chân thành cảm ơn quý vị đã lắng nghe !