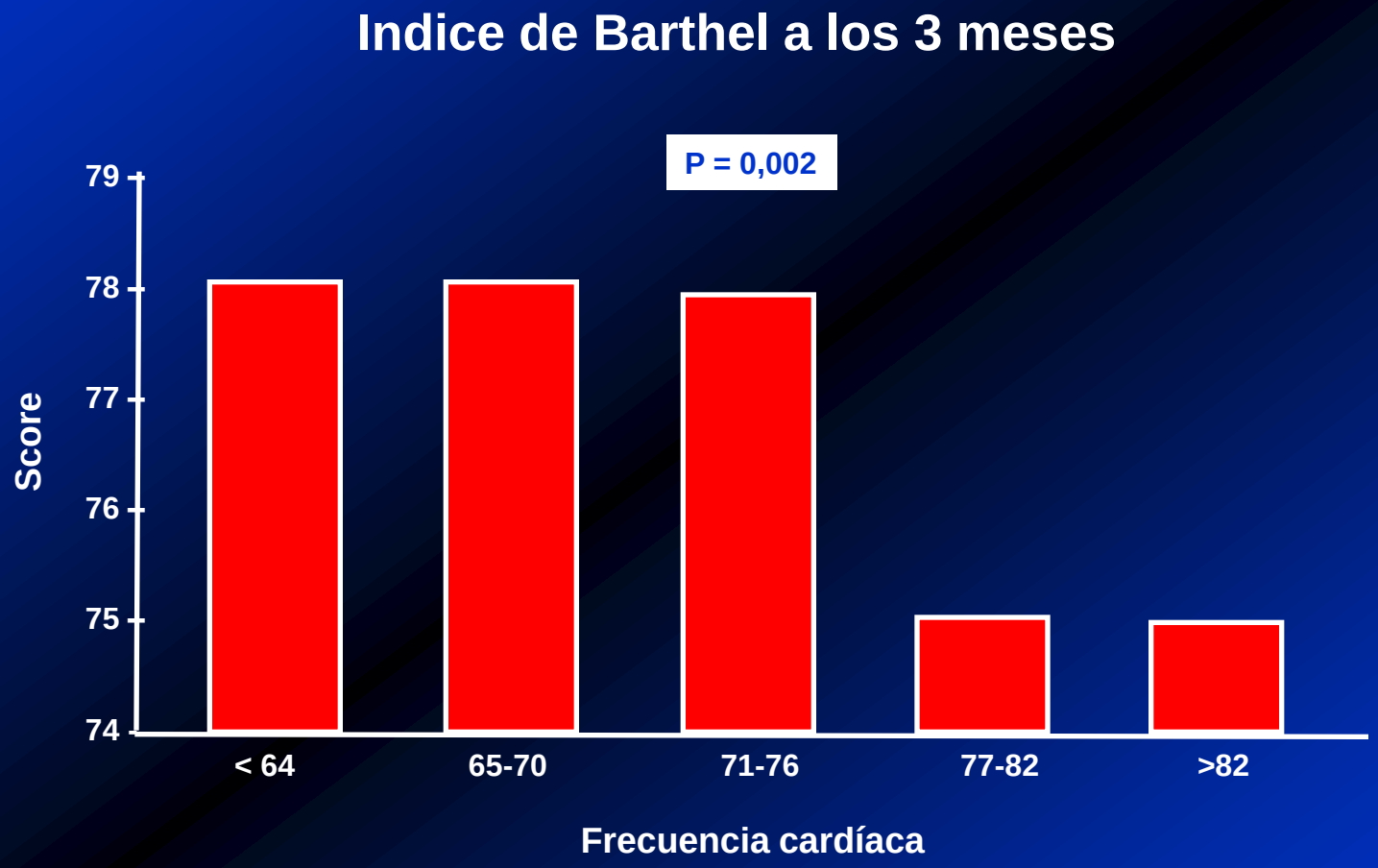
"Lo mejor del Congreso ESC de Munich"

Riesgo Vascular

Enrique Galve
Servicio de Cardiología
Hospital Universitario Vall d'Hebron Barcelona

PROFESS

Impacto de la FC basal sobre la mortalidad, discapacidad y deterioro cognitivo tras un AVC icquémico

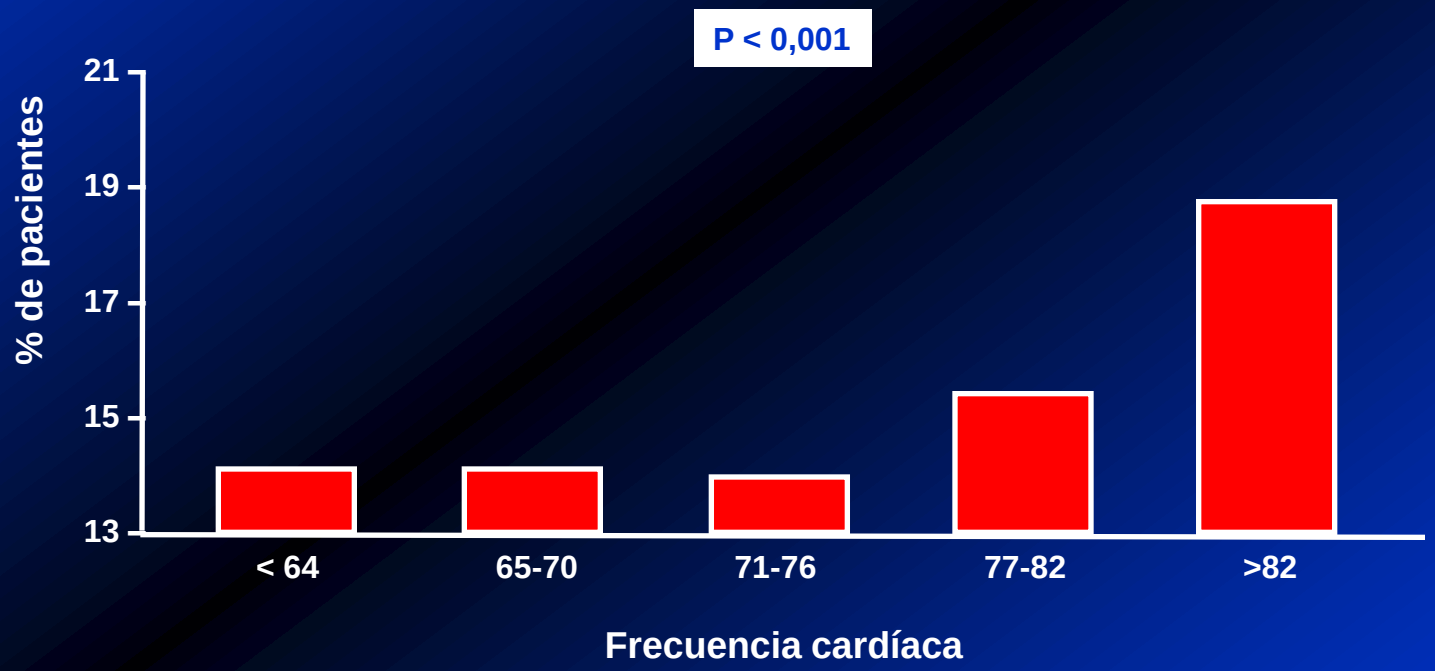


M Boehm 1126

PROFESS

Impacto de la FC basal sobre la mortalidad, discapacidad y deterioro cognitivo tras un AVC icquémico

Minimental Test < 24 (demencial inicial)



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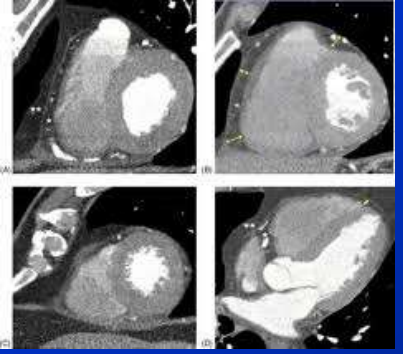

Asociación de grasa epicárdica con IAM en población general.

Modelo	Hazard ratio (IC 95%)	valor de p
Sin ajustar	2,24 (1,24 – 2,88)	< 0,001
Ajustado edad y sexo	1,63 (1,23 – 2,17)	0,001
+ factores riesgo convencionales	1,54 (1,09 – 2,19)	0,01
+ score cálcico coronario	1,50 (1,07– 2,11)	0,02

AA Mahabadi 2949

European Heart Journal (2012) **33**, 2088–2097
doi:10.1093/eurheartj/ehs075

CLINICAL RESEARCH
Hypertension

Angiotensin-converting enzyme inhibitors reduce mortality in hypertension: a meta-analysis of randomized clinical trials of renin–angiotensin–aldosterone system inhibitors involving 158 998 patients

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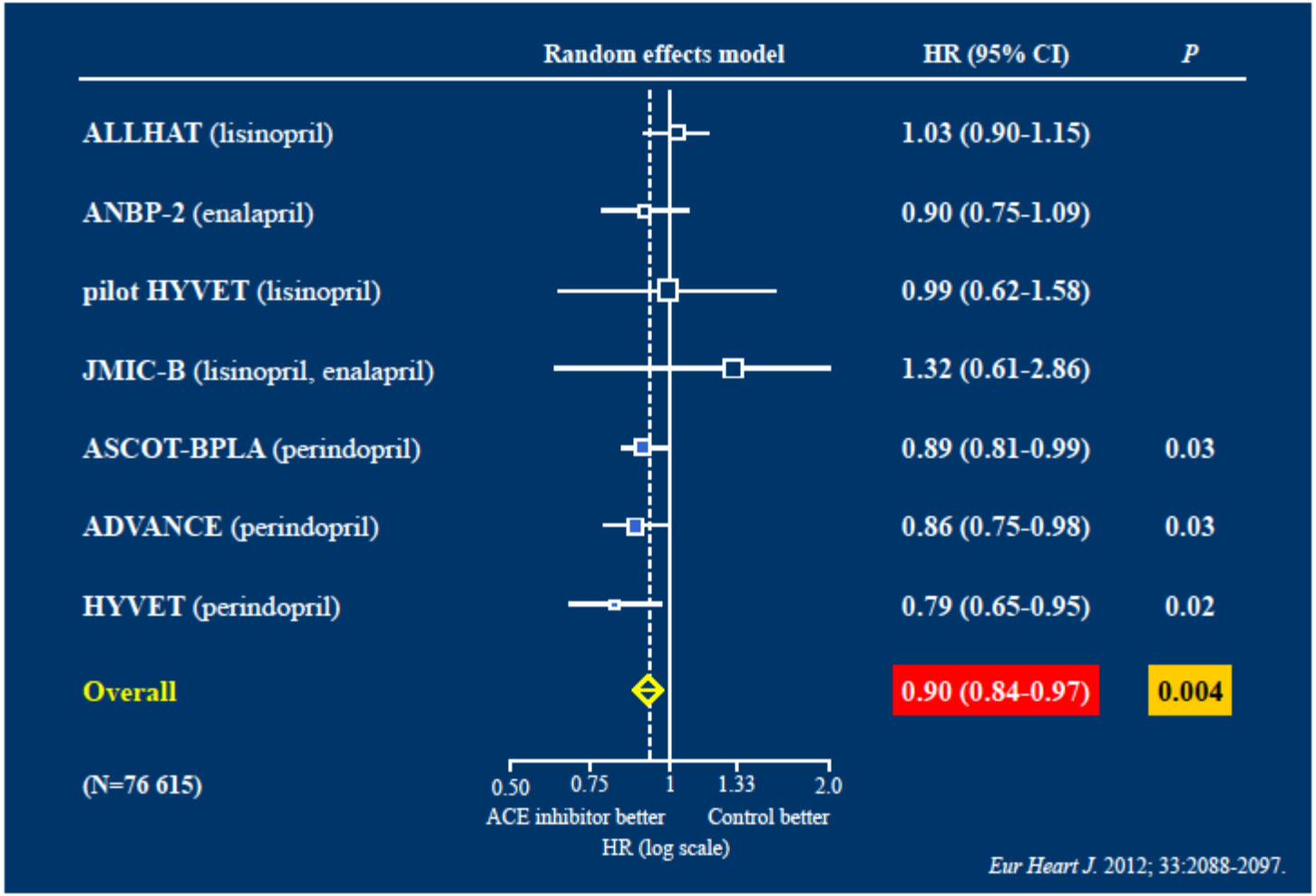
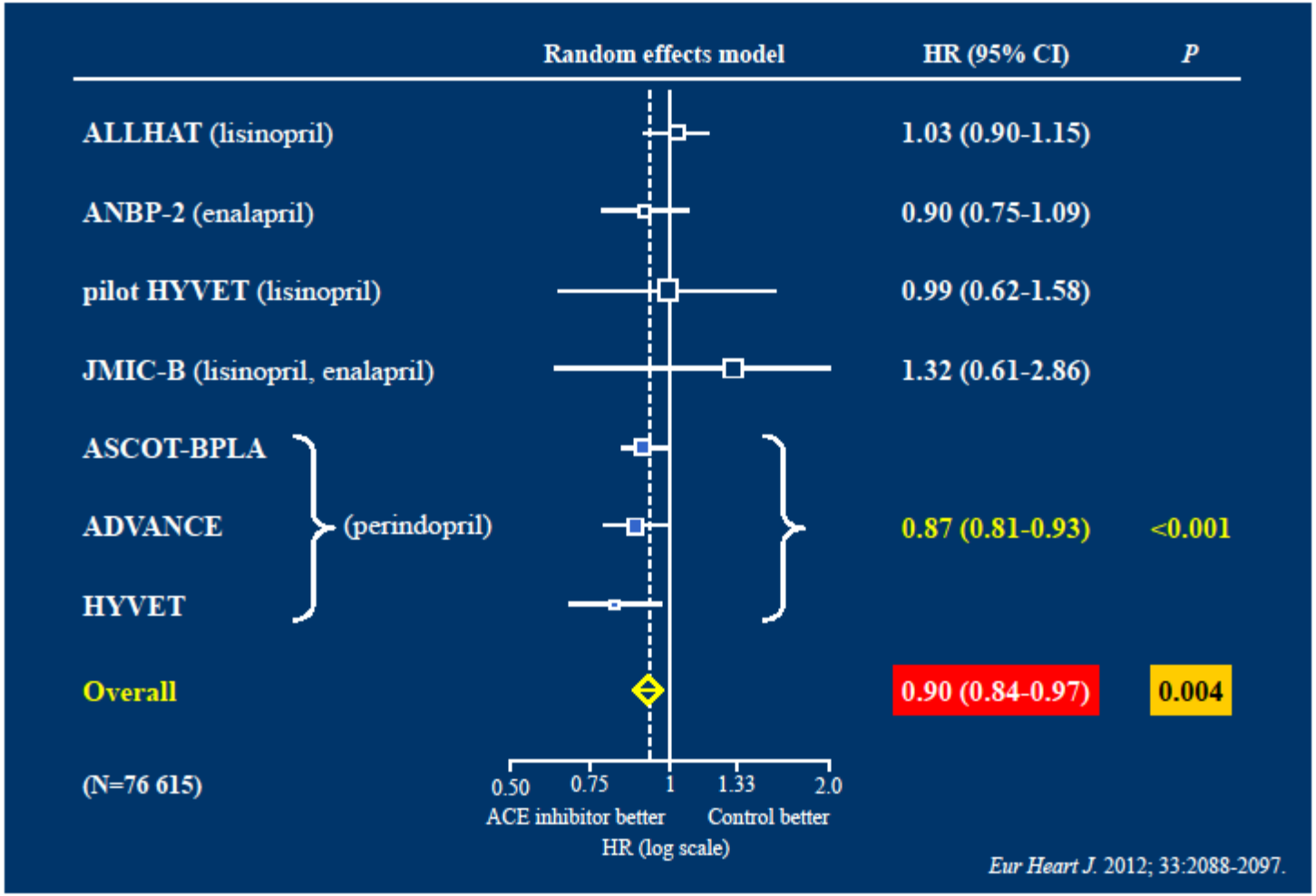
All-cause mortality: effect of ACE inhibitors



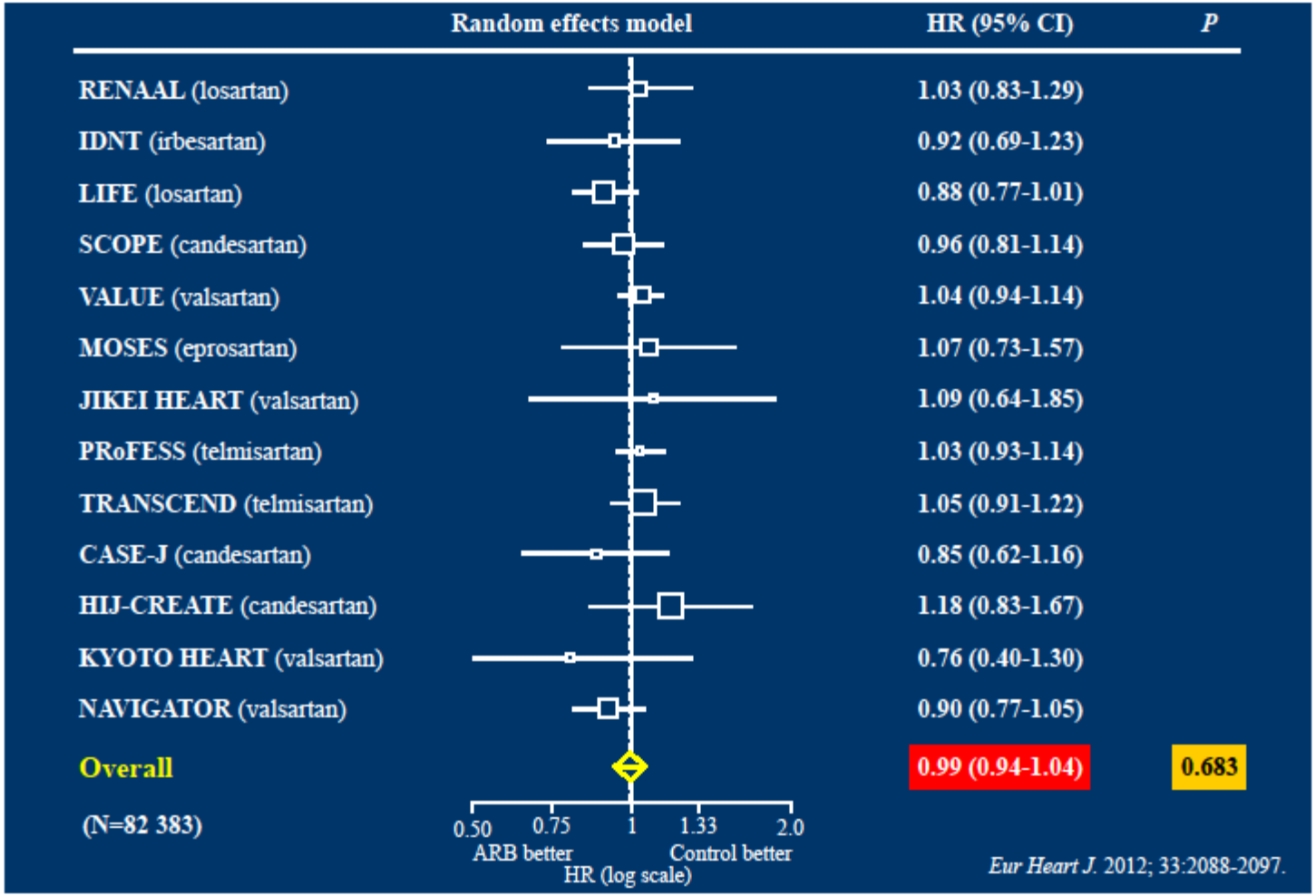
Eur Heart J. 2012; 33:2088-2097.

All-cause mortality: effect of ACE inhibitors



Eur Heart J. 2012; 33:2088-2097.

All-cause mortality: effect of ARBs



Eur Heart J. 2012; 33:2088-2097.

ALTITUDE: Aliskirén en diabéticos con enfermedad renal

Stop: diciembre 2011

ALISKIREN vs PCB (+IECAs/ARA2 en ambos brazos) en diabéticos con enfermedad renal (FG<60 ó macroalbuminuria)

Objetivo: disminuir eventos CV y renales

	ALISKIREN	PLACEBO	
End-point principal	*767 (17,9%)*	*721 (16,8%)*	*p=0,14*
Ictus	*146 (3,4%)*	*118 (2,7%)*	*p=0,07*
$K^+ \geq 6,0$	*(8,8%)*	*(5,6%)*	

Parving HH et al.

ALTITUDE: Aliskirén en diabéticos con enfermedad renal

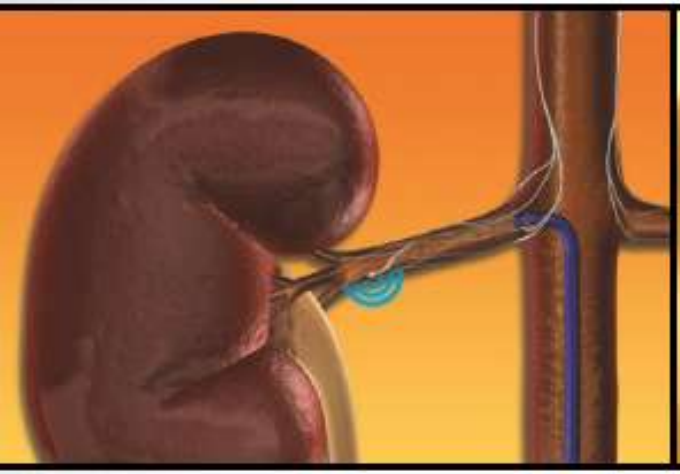
Stop: diciembre 2011

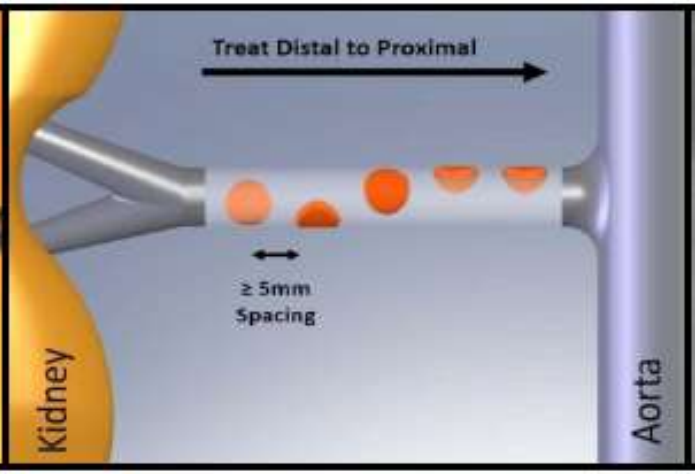
¿El riesgo es debido al propio aliskirén, ó al doble bloqueo?

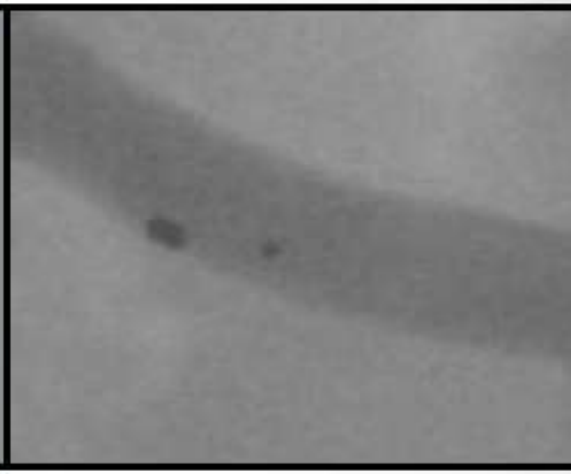
Ictus	146 (3,4%)	118 (2,7%)	p=0.07
$K^+ \geq 6,0$	(8,8%)	(5,6%)	

Parving HH et al.

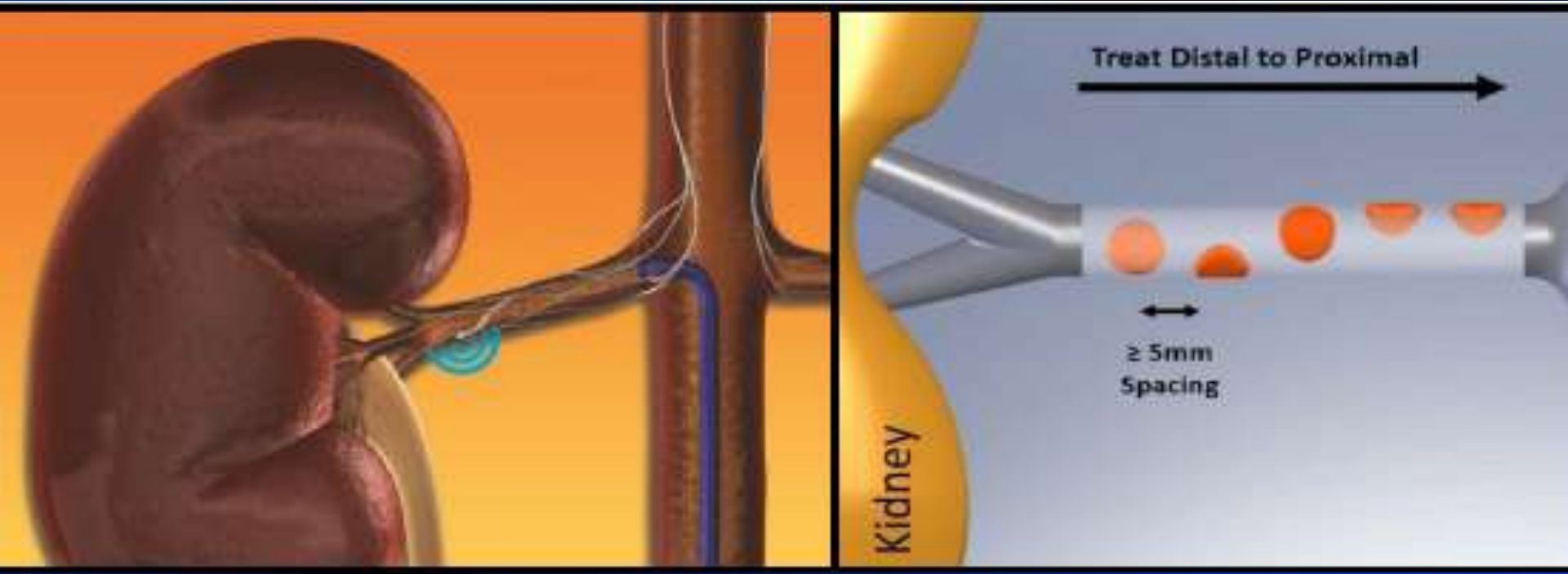
Catheter-Based Radiofrequency Renal Nerve Ablation



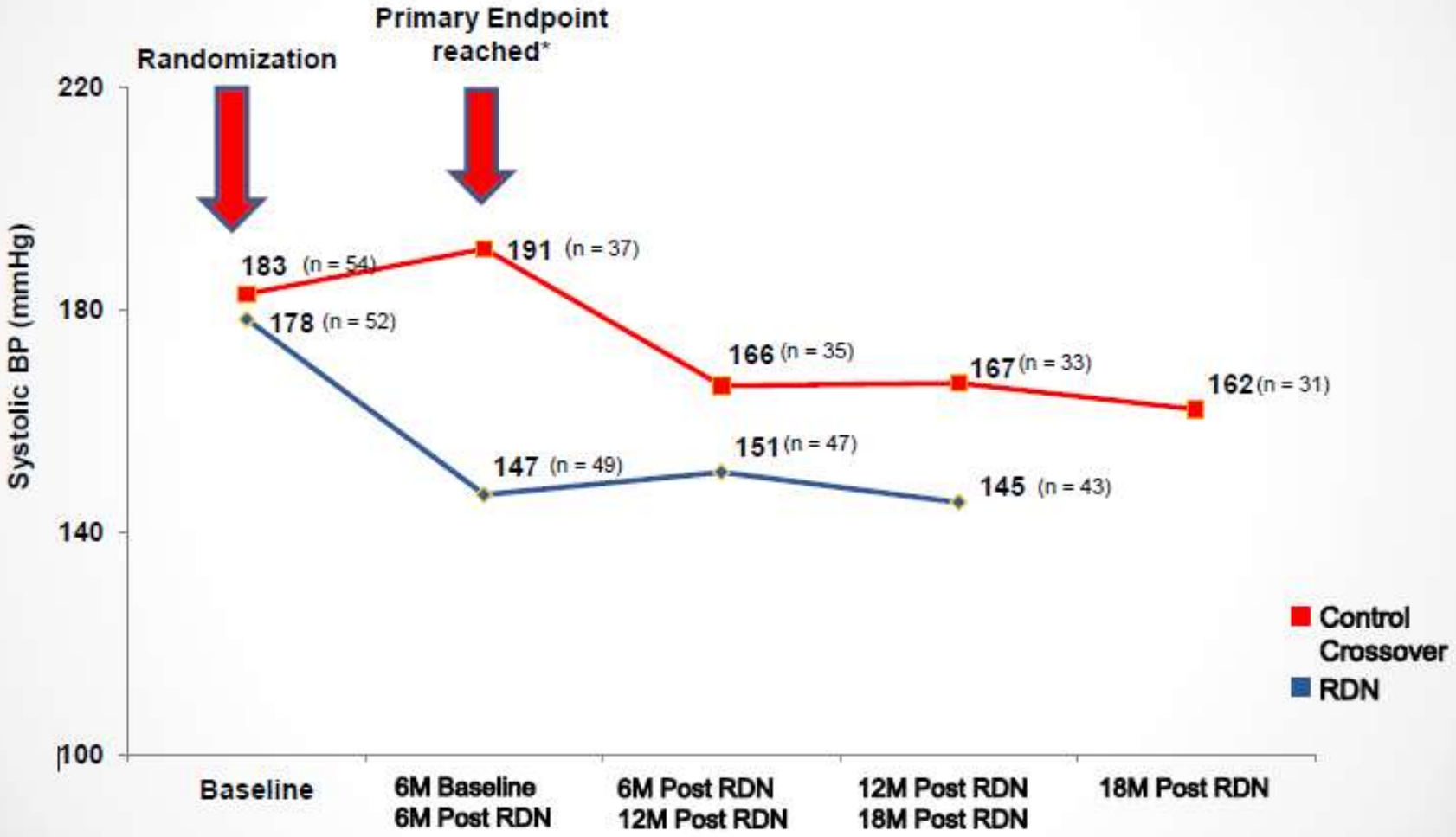




- Standard interventional technique
- 4-6 two-minute treatments per artery
- Proprietary RF Generator
  - Automated
  - Low-power
  - Built-in safety algorithms


Treat Distal to Proximal
≥ 5mm
Spacing
Kidney

Office BP 18 months Post Procedure



*Patients randomized to control were offered RDN following the primary endpoint assessment. Only patients still meeting entry criteria (SBP ≥ 160 mmHg) were included in this analysis (n=37)

Office BP 18 months Post Procedure

- **Eficaz: reduce PA 30mmHg**
- **No reinervación posterior**
- **Pocas complicaciones**
- **Exclusiones: arteriopatía renal e insuficiencia renal**
- **Gran expansión: > 5.000 casos efectuados**

Only patients still meeting entry criteria (SBP ≥ 160 mmHg) were included in this analysis (n=37)

European Heart Journal
doi:10.1093/eurheartj/ehs092

European Guidelines on cardiovascular disease prevention in clinical practice (version 2012)

The Fifth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of nine societies and by invited experts)

Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR)†

Authors/Task Force Members: Joep Perk (Chairperson) (Sweden)*, Guy De Backer[1] (Belgium), Helmut Gohlke[1] (Germany), Ian Graham[1] (Ireland), Željko Reiner[2] (Croatia), Monique Verschuren[1] (The Netherlands), Christian Albus[3] (Germany), Pascale Benlian[1] (France), Gudrun Boysen[4] (Denmark), Renata Cifkova[5] (Czech Republic), Christi Deaton[1] (UK), Shah Ebrahim[1] (UK), Miles Fisher[6] (UK), Giuseppe Germano[1] (Italy), Richard Hobbs[17] (UK), Arno Hoes[7] (The Netherlands), Sehnaz Karadeniz[8] (Turkey), Alessandro Mezzani[1] (Italy), Eva Prescott[1] (Denmark), Lars Ryden[1] (Sweden), Martin Scherer[7] (Germany), Mikko Syvänne[9] (Finland), Wilma J.M. Scholte Op Reimer[1] (The Netherlands), Christiaan Vrints[1] (Belgium), David Wood[1] (UK), Jose Luis Zamorano[1] (Spain), Faiez Zannad[1] (France).

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† Other ESC entities having participated in the development of this document:

Associations: European Association of Echocardiography (EAE), European Association of Percutaneous Cardiovascular Interventions (EAPCI), European Heart Rhythm Association (EHRA), Heart Failure Association (HFA)

Working Groups: Acute Cardiac Care, e-Cardiology, Cardiovascular Pharmacology and Drug Therapy, Hypertension and the Heart.

Councils: Basic Cardiovascular Science, Cardiology Practice, Cardiovascular Imaging, Cardiovascular Nursing and Allied Professions, Cardiovascular Primary Care.

Recomendaciones manejo hiperlipidemia

Recommendations	Class[a]	Level[b]	GRADE
The recommended target levels are <5 mmol/L (less than ~190 mg/dL) for total plasma cholesterol and <3 mmol/L (less than ~115 mg/dL) for LDL cholesterol for subjects at low or moderate risk.	I	A	Strong
In patients at high CVD risk, an LDL cholesterol goal <2.5 mmol/L (less than ~100 mg/dL) is recommended.	I	A	Strong
In patients at very high CVD risk, the recommended LDL cholesterol target is <1.8 mmol/L (less than ~70 mg/dL) or a ≥50% LDL cholesterol reduction when the target level cannot be reached.	I	A	Strong
All patients with familial hypercholesterolaemia must be recognized as high-risk patients and be treated with lipid-lowering therapy.	I	A	Strong
In patients with an ACS, statin treatment in high doses has to be initiated while the patients are in hospital.	I	A	Strong
Prevention of non-haemorrhagic stroke: treatment with statins must be started in all patients with established atherosclerotic disease and in patients at high risk for developing CVD. Treatment with statins must be started in patients with a history of non-cardioembolic ischaemic stroke.	I	A	Strong
Occlusive arterial disease of the lower limbs and carotid artery disease are CHD risk-equivalent conditions and lipid-lowering therapy is recommended.	I	A	Strong
Statins should be considered as the first-line drugs in transplant patients with dyslipidaemia.	IIa	B	Strong
Chronic kidney disease (stages 2–5, i.e. GFR <90 mL/min/1.73 m^2) is acknowledged as a CHD risk-equivalent and the LDL cholesterol target in these patients should be adapted to the degree of renal failure.	IIa	C	Strong

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European Heart Journal (2011) 32, 1900–1908
doi:10.1093/eurheartj/ehr077

CLINICAL RESEARCH
Prevention

Mortality and cardiovascular risk associated with different insulin secretagogues compared with metformin in type 2 diabetes, with or without a previous myocardial infarction: a nationwide study

Tina Ken Schramm[1]*, Gunnar Hilmar Gislason[2], Allan Vaag[3], Jeppe Nørgaard Rasmussen[4], Fredrik Folke[5], Morten Lock Hansen[2], Emil Loldrup Fosbøl[2], Lars Køber[1], Mette Lykke Norgaard[2], Mette Madsen[6], Peter Riis Hansen[2], and Christian Torp-Pedersen[2]

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See page 1832 for the editorial comment on this article (doi:10.1093/eurheartj/ehr019)

Aims The impact of insulin secretagogues (ISs) on long-term major clinical outcomes in type 2 diabetes remains unclear. We examined mortality and cardiovascular risk associated with all available ISs compared with metformin in a nationwide study.

Methods and results All Danish residents >20 years, initiating single-agent ISs or metformin between 1997 and 2006 were followed for up to 9 years (median 3.3 years) by individual-level linkage of nationwide registers. All-cause mortality, cardiovascular mortality, and the composite of myocardial infarction (MI), stroke, and cardiovascular mortality associated with individual ISs were investigated in patients with or without previous MI by multivariable Cox proportional-hazard analyses including propensity analyses. A total of 107 806 subjects were included, of whom 9607 had previous MI. Compared with metformin, glimepiride (hazard ratios and 95% confidence intervals): 1.32 (1.24–1.40), glibenclamide: 1.19 (1.11–1.28), glipizide: 1.27 (1.17–1.38), and tolbutamide: 1.28 (1.17–1.39) were associated with increased all-cause mortality in patients without previous MI. The corresponding results for patients with previous MI were as follows: glimepiride: 1.30 (1.11–1.44), glibenclamide: 1.47 (1.22–1.76), glipizide: 1.53 (1.23–1.89), and tolbutamide: 1.47 (1.17–1.84). Results for gliclazide [1.05 (0.94–1.16) and 0.90 (0.68–1.20)] and repaglinide and [0.97 (0.81–1.15) and 1.29 (0.86–1.94)] were not statistically different from metformin in both patients without and with previous MI, respectively. Results were similar for cardiovascular mortality and for the composite endpoint.

Conclusion Monotherapy with the most used ISs, including glimepiride, glibenclamide, glipizide, and tolbutamide, seems to be associated with increased mortality and cardiovascular risk compared with metformin. Gliclazide and repaglinide appear to be associated with a lower risk than other ISs.

Keywords Diabetes type 2 • Insulin secretagogues • Metformin • Mortality • Cardiovascular disease • Population

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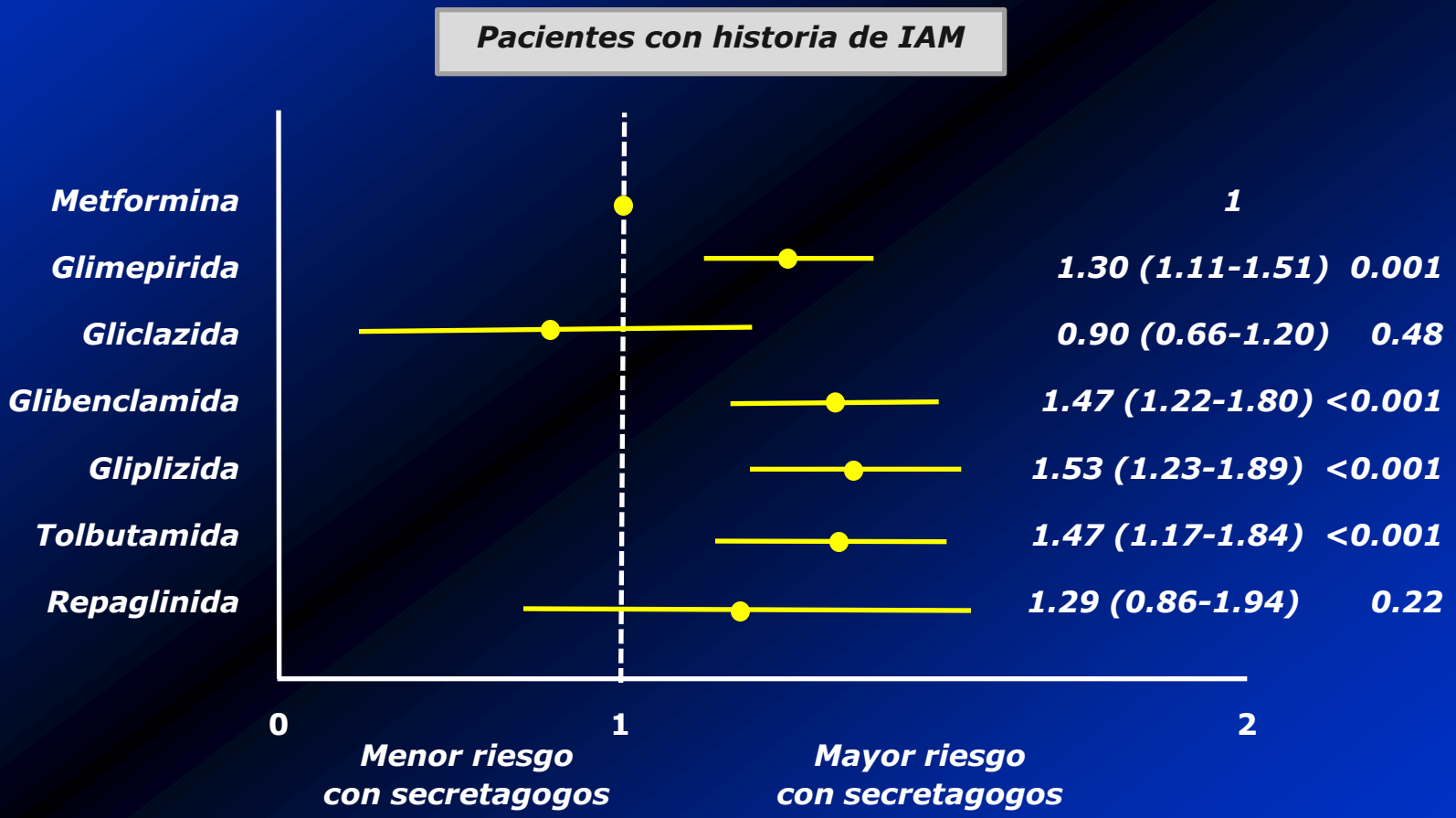
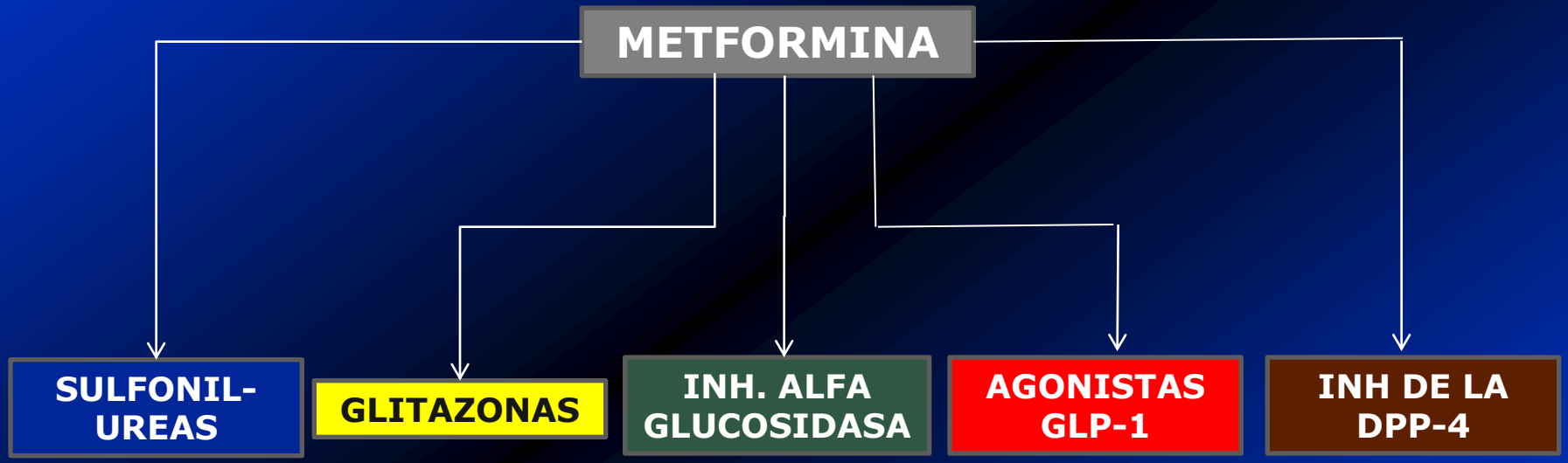
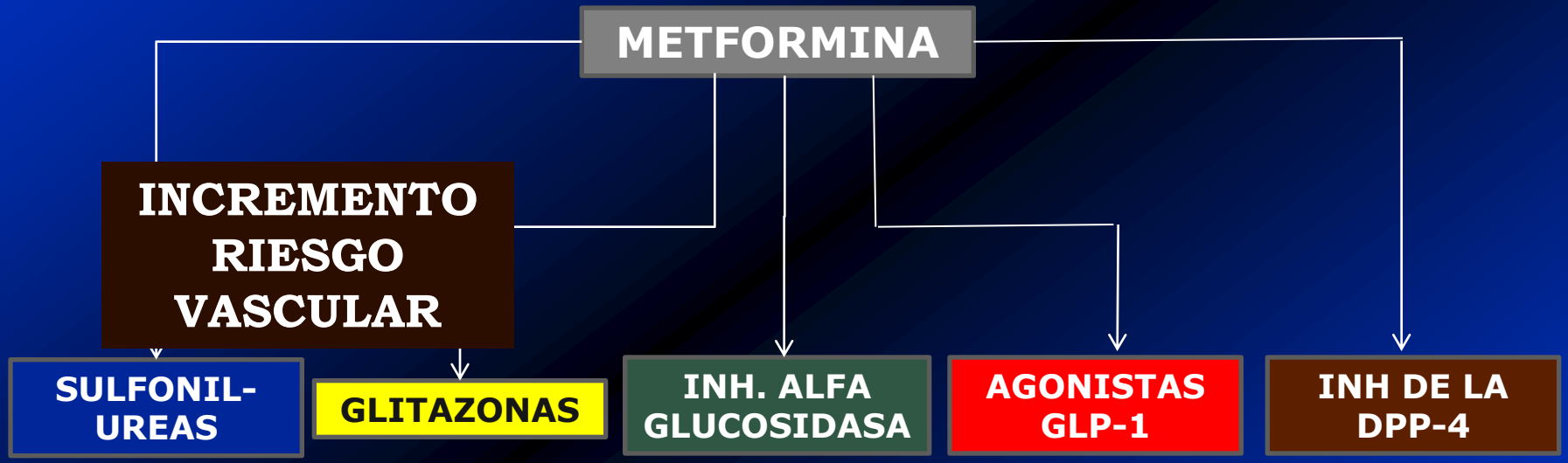
Riesgo CV asociado a diversos secretagogos de insulina



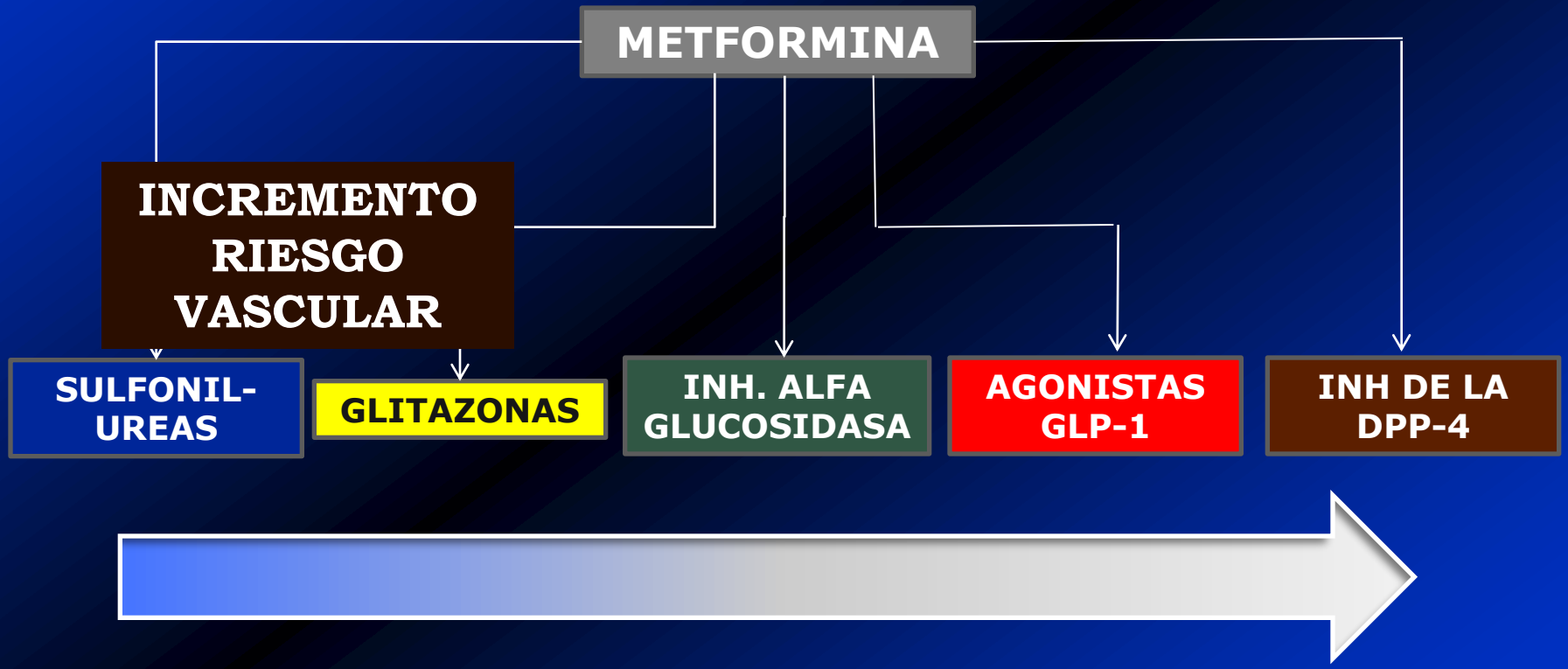
Hipoglucemiantes orales



Hipoglucemiantes orales



Hipoglucemiantes orales



Muchas gracias