

Lo mejor del CONGRESO ESC 2013

# RIESGO CARDIOVASCULAR

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Hospital Universitario La Paz

# ESC 2013 Riesgo Cardiovascular

## 1. Estado actual Prevención :

- PURE
- EuroAspire IV
- BARIHD

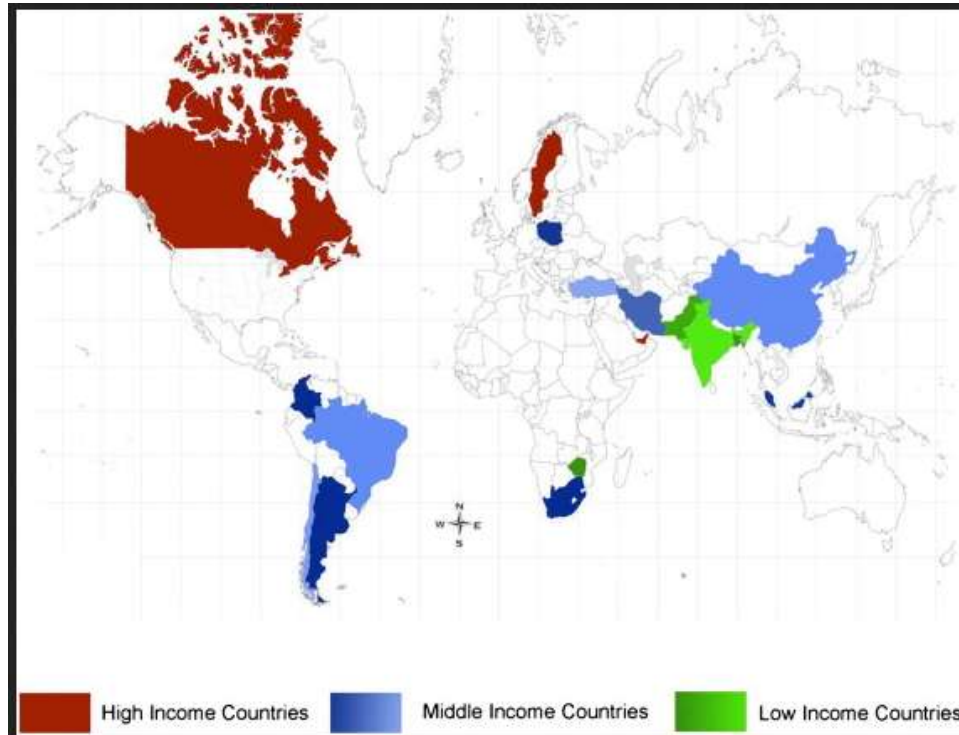
## 2. Diabetes:

- Guías Práctica Clínica
- Ensayos Clínicos:
  - SAVOR-TIMI 53
  - EXAMINE
  - ORIGIN

## 3. HTA:

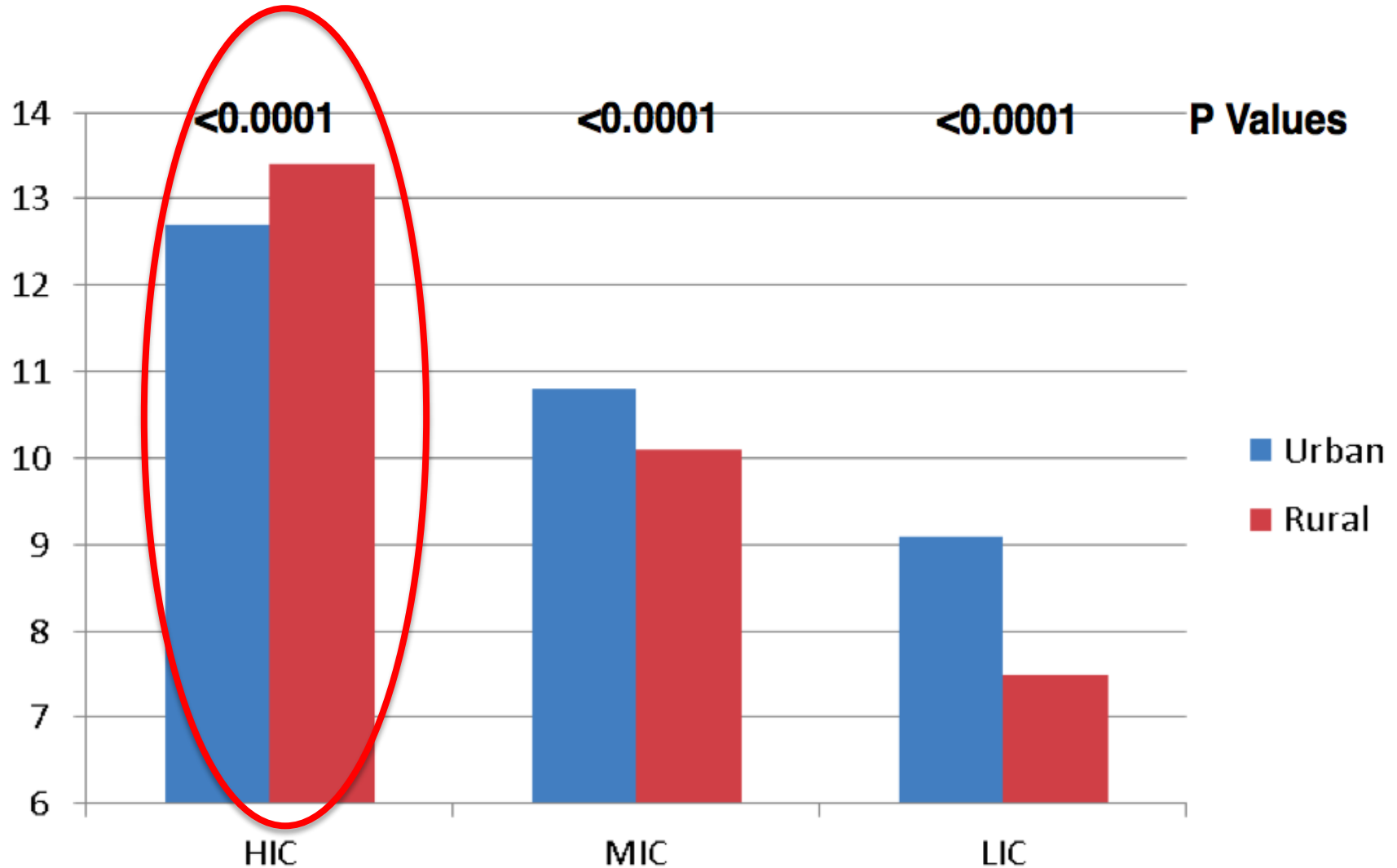
- Guías Práctica Clínica
- Simplicity HTN1

# PURE (Prospective Urban Rural Epidemiologic) Study

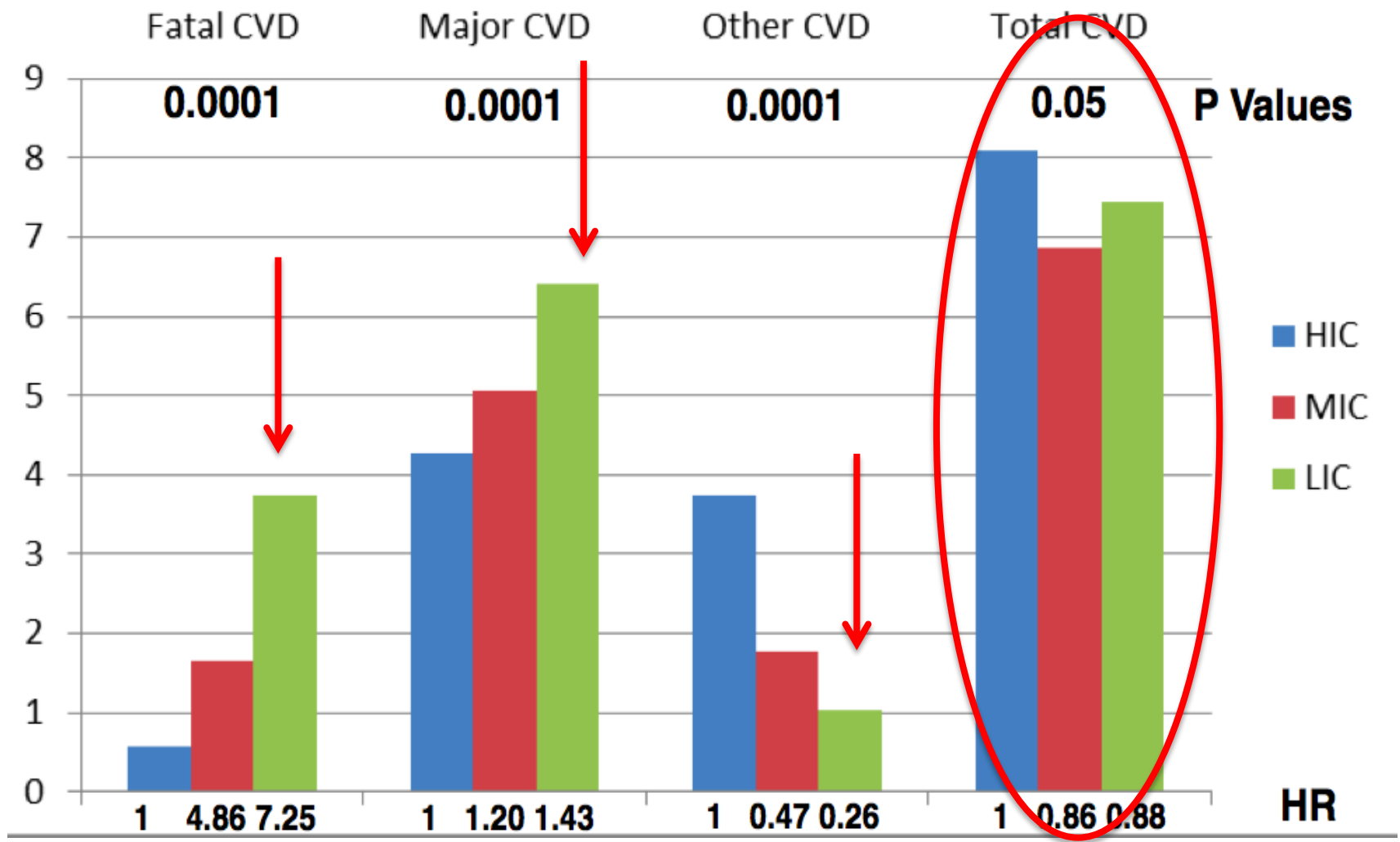


¿Qué asociación existe entre los factores sociales y los factores de riesgo cardiovascular, la frecuencia de eventos y la mortalidad?

# Presencia de FRCV ( INTERHEART Risk Score)



# Incidencia eventos CV ( 1000 p/año)





# EUROASPIRE IV Countries



Ireland



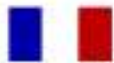
Netherlands



Germany



UK



France



Czech Republic



Croatia



Belgium



Spain



Slovenia



Serbia



Italy



Finland



Latvia



Poland



Romania



Greece



Cyprus



Russia



Sweden



Lithuania



Hungary



Bulgaria



Turkey



Ukraine



EUROPEAN SOCIETY OF CARDIOLOGY®

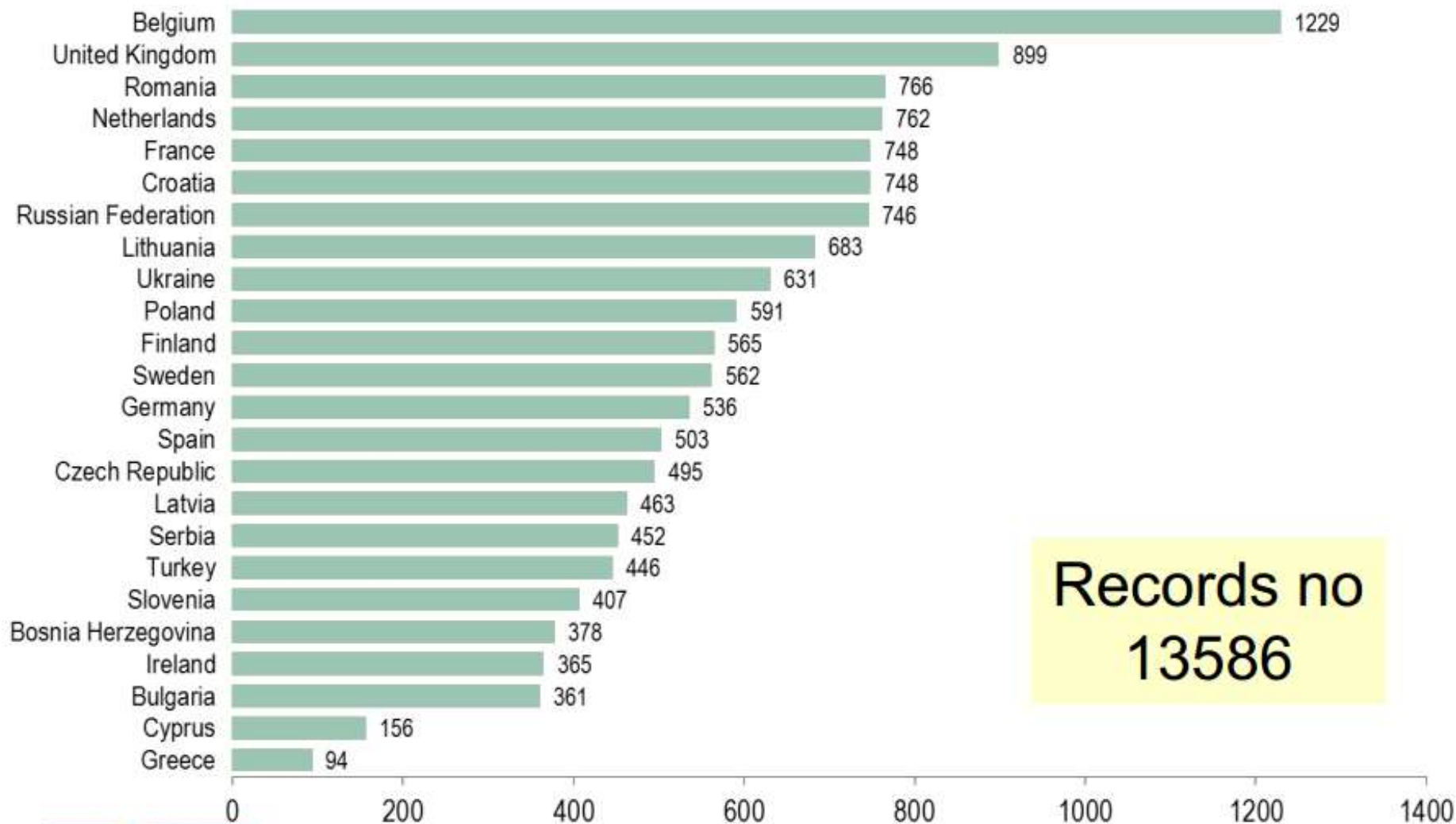
[www.escardio.org](http://www.escardio.org)  
Bosnia and Herzegovina

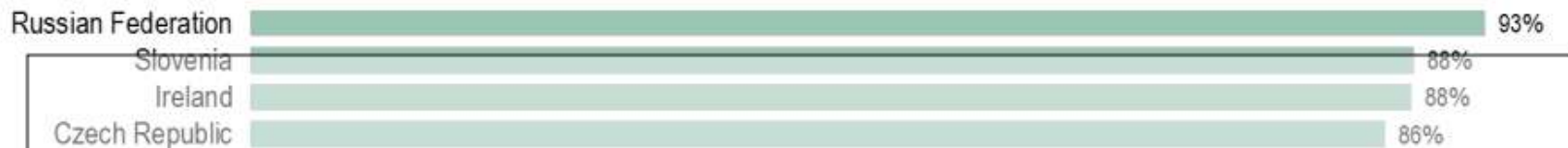
amsterdam  
ESC CONGRESS 2013

#POSTESC13

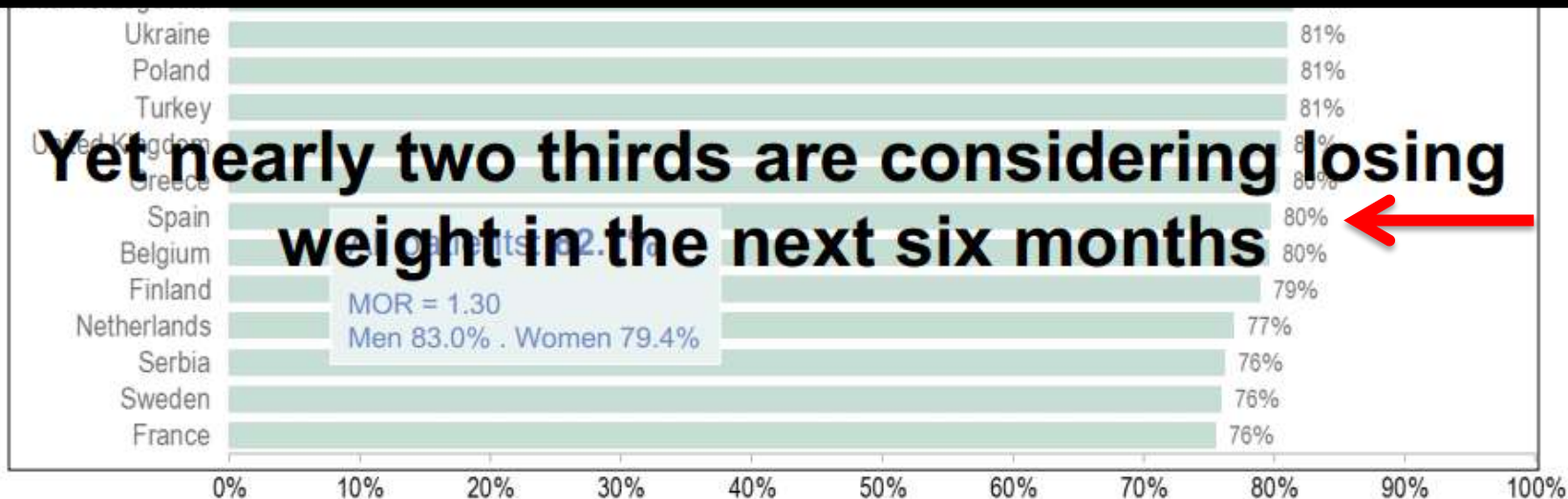
# Euroaspire IV

## Number of medical records





4 de cada 5 pacientes tienen sobrepeso y un tercio son obesos



\* Body Mass Index  $\geq 25$  kg/m<sup>2</sup>

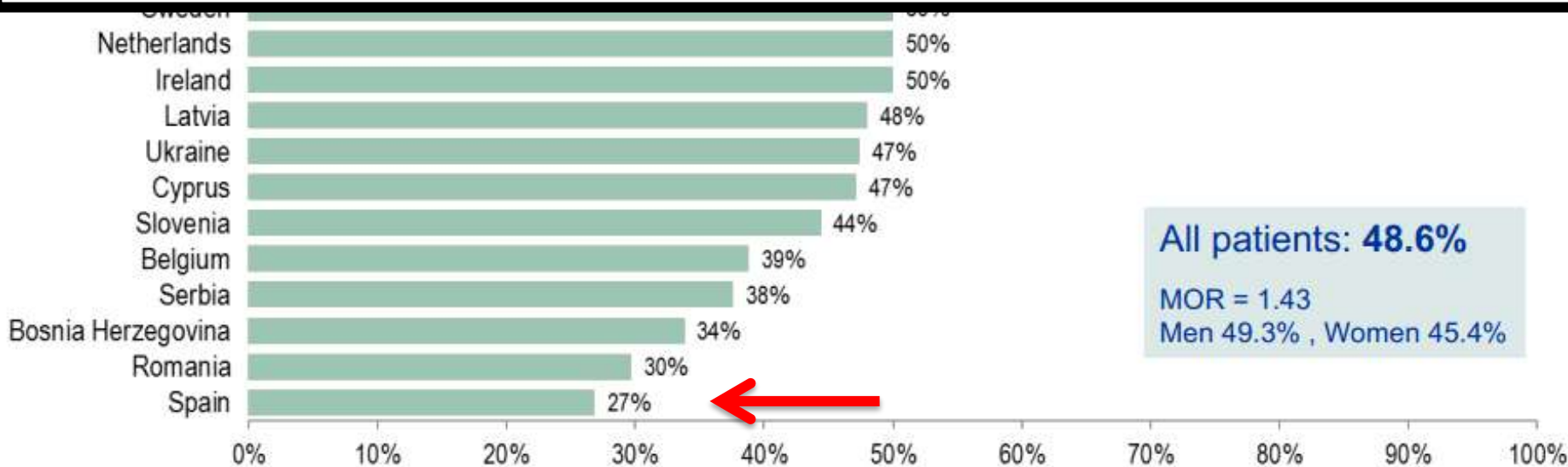




# Prevalence of persistent smoking\*



Casi la mitad de los pacientes siguen fumando tras un evento coronario

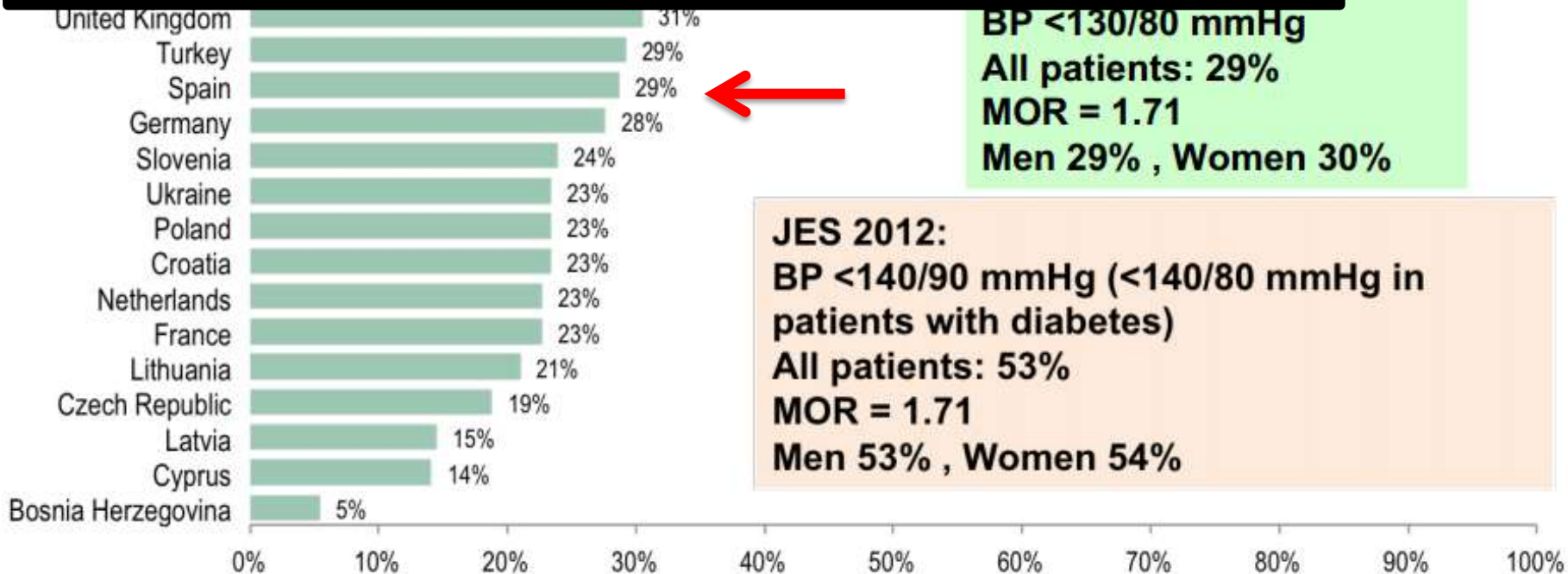




# Therapeutic control of blood pressure \*



Sólo se alcanza el control de TA en un 53% de los pacientes



**BP <130/80 mmHg**  
**All patients: 29%**  
**MOR = 1.71**  
**Men 29% , Women 30%**

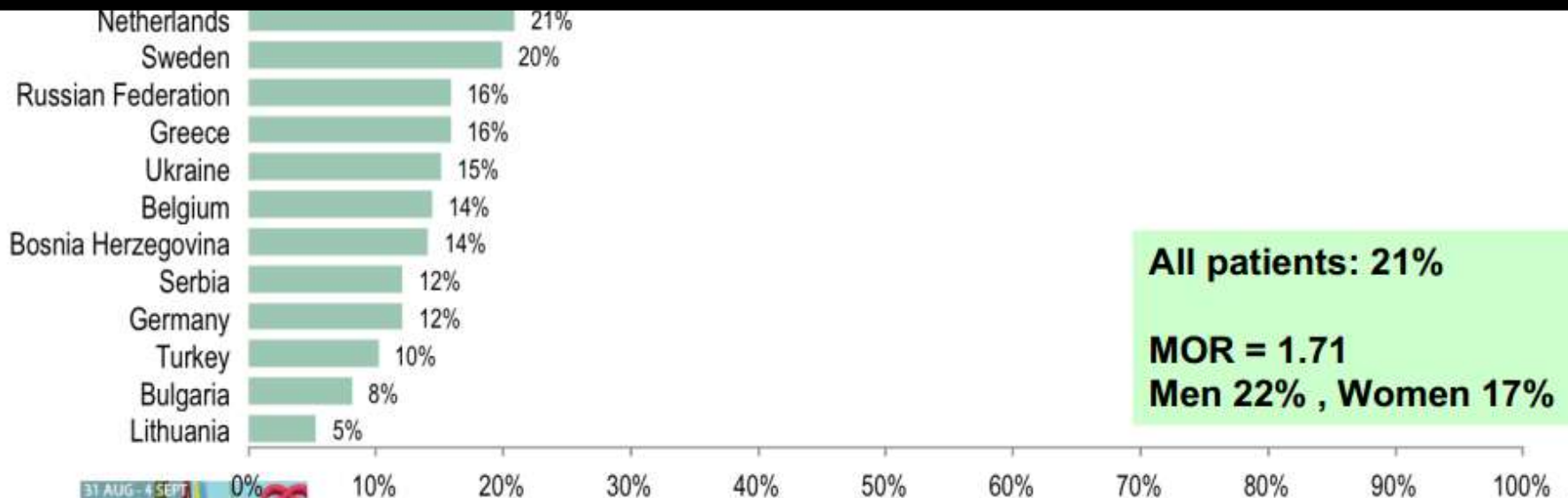
**JES 2012:**  
**BP <140/90 mmHg (<140/80 mmHg in patients with diabetes)**  
**All patients: 53%**  
**MOR = 1.71**  
**Men 53% , Women 54%**



# LDL cholesterol < 70 mg/dl patients on lipid-lowering medication



Menos de un tercio de los pacientes están en cifras de LDL objetivo

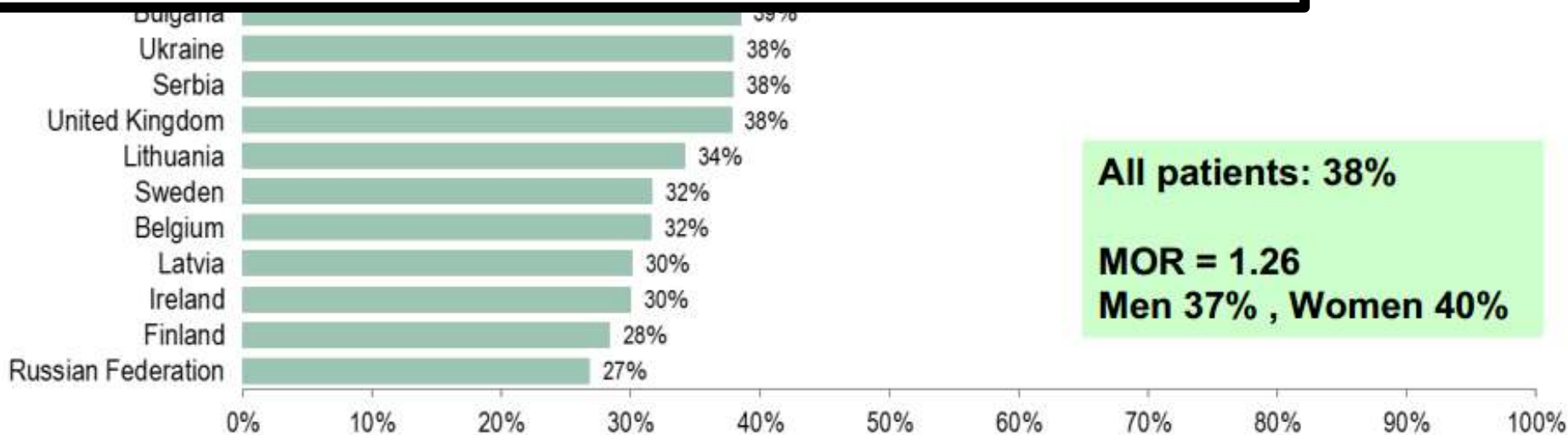


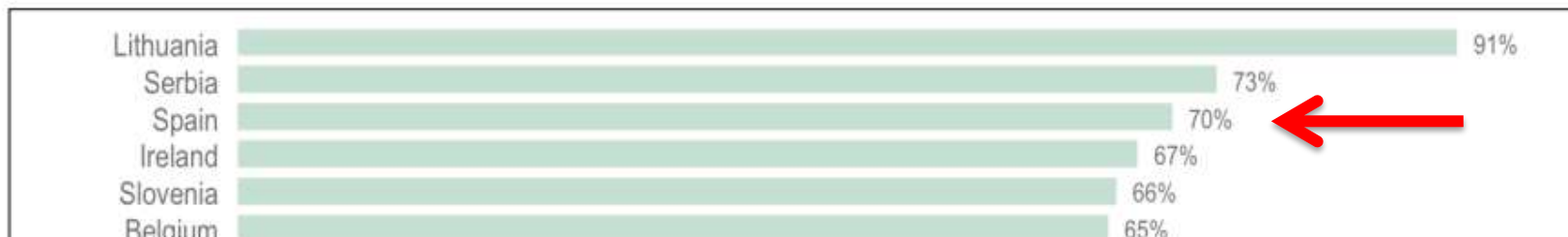


# Prevalence of diabetes mellitus\*

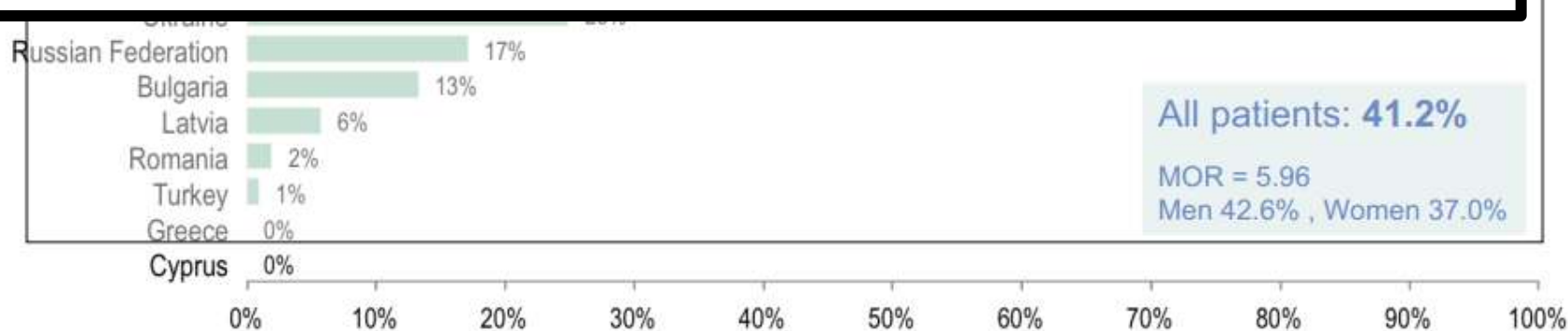


En torno a un 40% de los pacientes son diabéticos

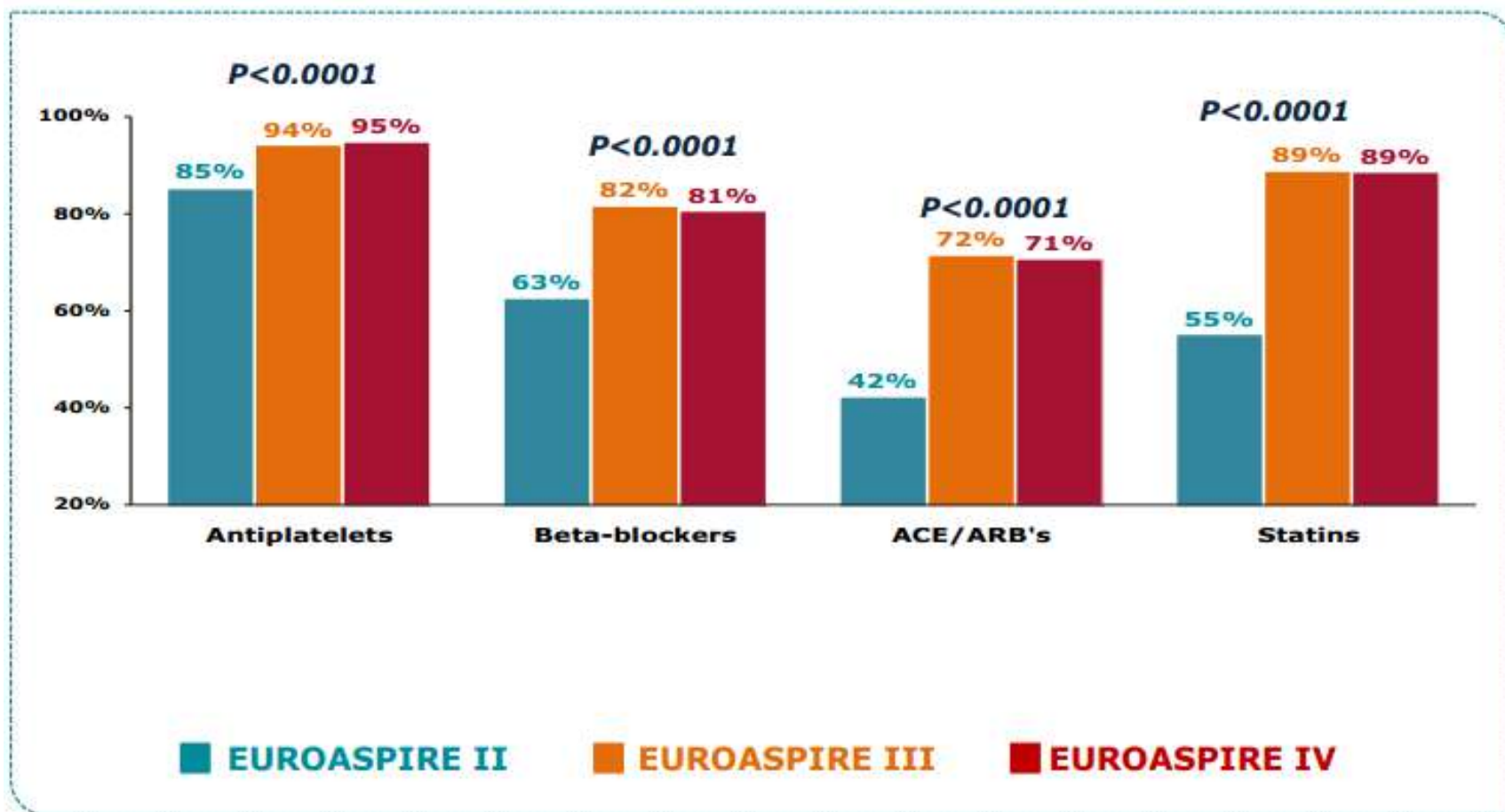


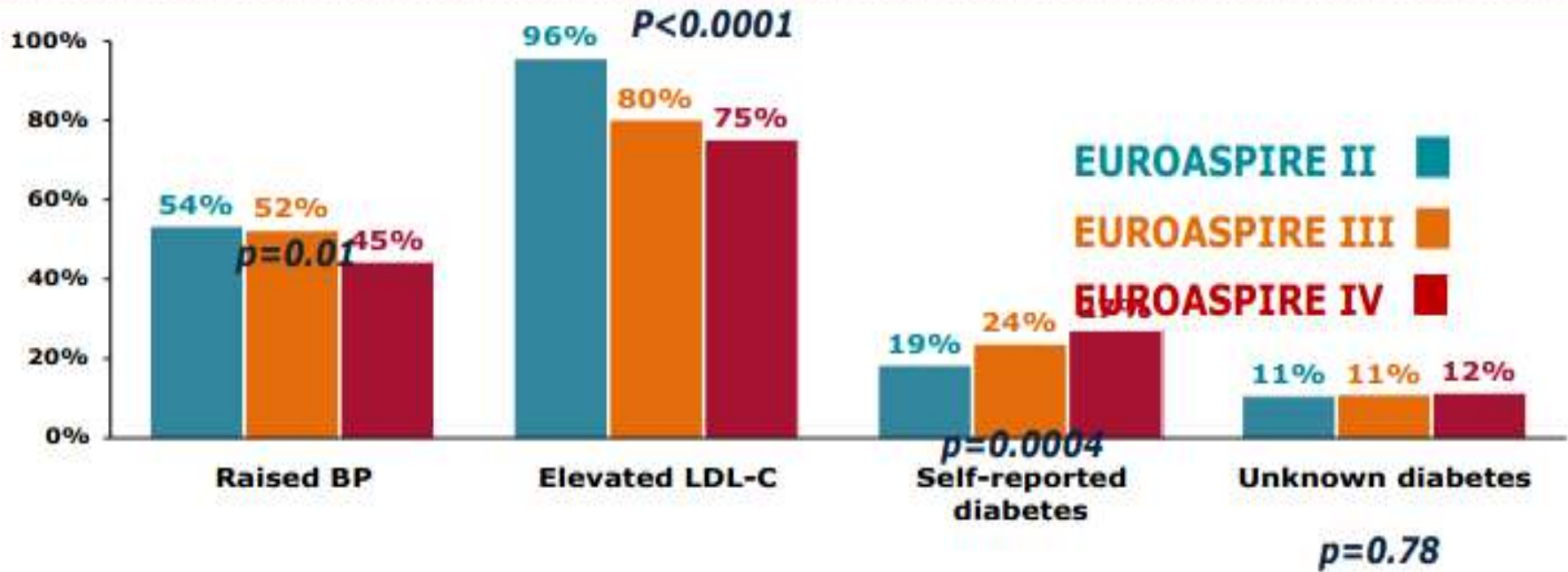


Menos de la mitad de los pacientes son remitidos a un programa de Prevención Secundaria



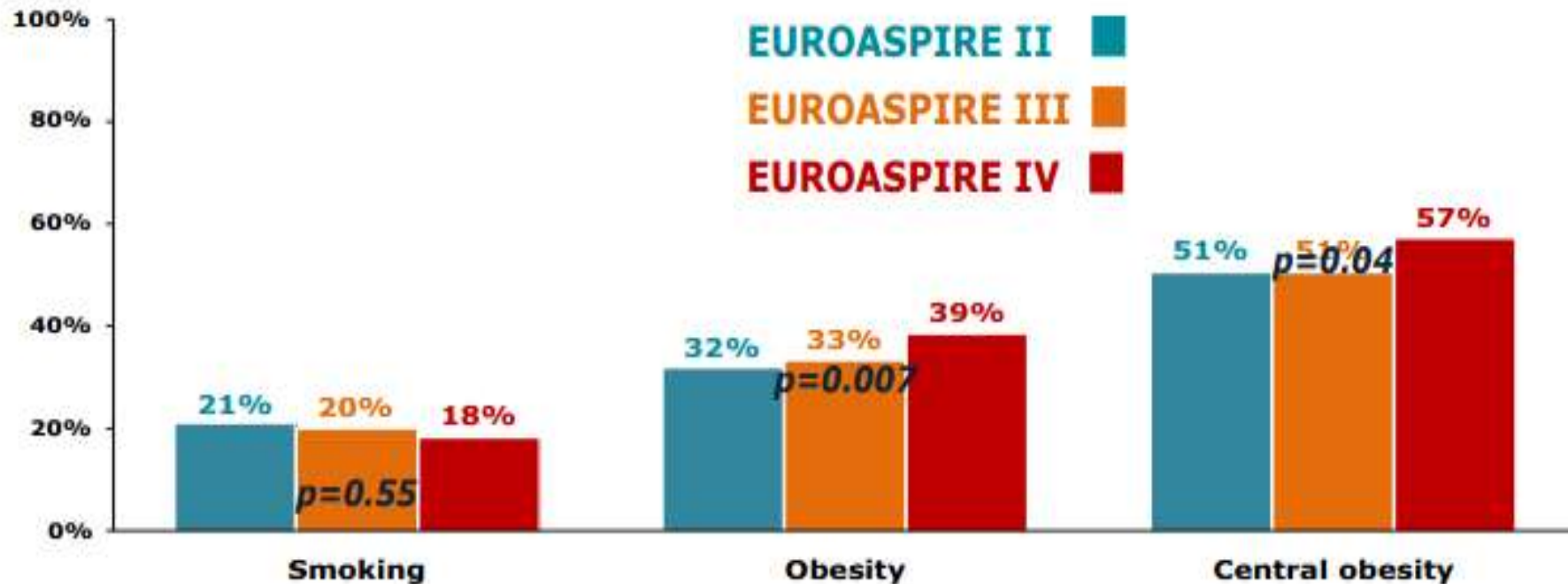
# Prescripción de Fármacos en P 2daria por encima del 80%





Peor control de FRCV

\* SBP/DBP  $\geq 140/90$  mmHg ( $\geq 140/80$  mmHg for patients with diabetes); LDL  $\geq 1.8$  mmol/L;  
 \*\*\*Fasting glucose  $\geq 7$  mmol/L for patients without history of diabetes



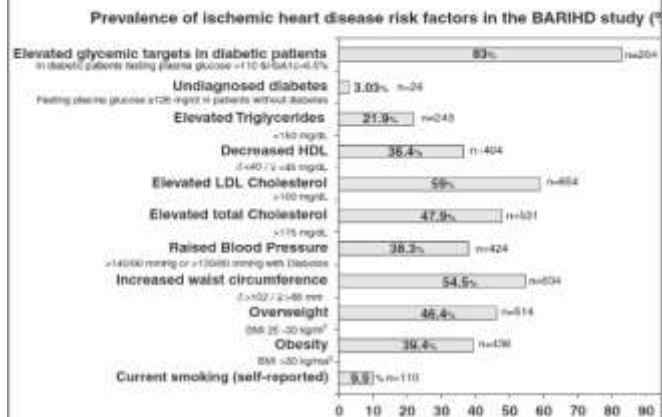
Peor control de FRCV

\* BMI  $\geq 30$  kg/m<sup>2</sup>; \*\*Waist circumference  $\geq 88$  cm for women and  $\geq 102$  cm for men

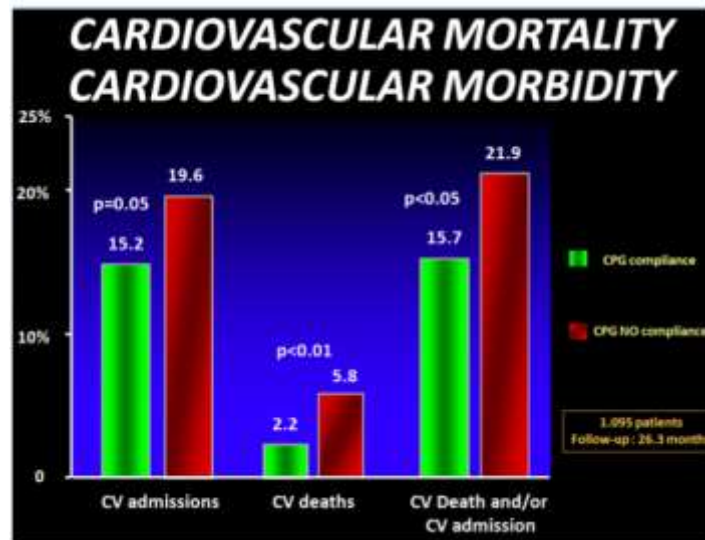
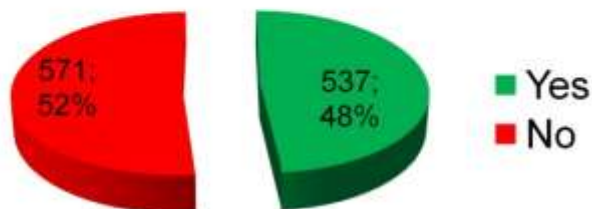


R C. Vidal Perez, F. Otero-Ravina, V. Turrado Turrado, J. Maestro Saavedra, J. Dopico Pita, C. Iglesias Díaz, JM. Solla Camino, J. Alvear García, P. de Blas Abad, JR. Gonzalez-Juanatey, on behalf of BARIHD investigators.  
University Clinical Hospital of Santiago de Compostela, Santiago de Compostela, Spain

## RESULTS N=1108 patients



## Clinical Practice Guidelines Compliance



## Multivariate analysis for CV mortality

	HR	95%CI	P-value
CPGC	0.47	0.24-0.93	0.031
Diabetes	1.98	1.09-3.57	0.023
Previous hear failure	4.41	2.40-8.09	0.001
Renal failure (glomerular filtration rate $< 60$ )	2.40	1.30-4.47	0.005
Physical exercise	0.43	0.24-0.78	0.006

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# Diagnosis of Glucose Perturbations

## Se simplifica el diagnóstico

Recommendations	Class	Level
It is recommended that the diagnosis of diabetes is based on HbA <sub>1c</sub> and FPG combined or on an OGTT if still in doubt.	I	B
It is recommended that an OGTT is used for diagnosing IGT.	I	B
It is recommended that screening for potential T2DM in people with CVD is initiated with HbA <sub>1c</sub> and FPG and that an OGTT is added if HbA <sub>1c</sub> and FPG are inconclusive.	I	A

**Not** – to when needed  
not perform an

Oral Glucose  
Tolerance Test



# Risk Assessment

## Estratificación Riesgo Cardiovascular

Recommendations	Class	Level
It should be considered to classify patients with DM as at very high or high risk for CVD depending on the presence of concomitant risk factor and target organ damage.	IIa	B
It is indicated to estimate the urinary albumin excretion rate when performing risk stratification in patients with DM.	I	A
Screening for silent myocardial ischaemia may be considered in selected high risk patients with DM.	IIb	C

## Not – to base risk assessment on risk scores

Recommendations	Class	Level
It is not recommended to assess the risk for CVD in patients with DM based on risk scores developed for the general population.	III	B

# Manejo Multifactorial DM2

## Life style modification

Glycaemic control

**HA1C < 7%**  
( individualizar )

Antiplatelet therapy

**No en  
Prevención 1aria**



Blood pressure control

**< 140/85 mm Hg**  
**< 130/85 ( Proteinuria)**

Lipid control

**LDL < 70 mg/dl MAR**  
**< 100 o 50% AR**

# Revascularización

Recommendations	Class	Level
Optimal medical treatment should be considered as preferred treatment in patients with stable CAD and DM unless there are large areas of ischaemia or significant left main or proximal LAD lesion.	<b>IIa</b>	<b>B</b>
CABG is recommended in patients with DM and multivessel or complex (SYNTAX Score >22) CAD to improve survival free from major cardiovascular events.	<b>I</b>	<b>A</b>
PCI for symptom control may be considered as an alternative to CABG in patients with DM and less complex multivessel CAD (SYNTAX score ≤22) in need of revascularization.	<b>IIb</b>	<b>B</b>
Primary PCI is recommended over fibrinolysis in DM patients presenting with STEMI if performed within recommended time limits.	<b>I</b>	<b>B</b>
In DM patients subjected to PCI, DES rather than BMS are recommended to reduce risk of target vessel revascularization.	<b>I</b>	<b>A</b>
Renal function should be carefully monitored after coronary angiography/PCI in all patients on metformin.	<b>I</b>	<b>C</b>
If renal function deteriorates in patients on metformin undergoing coronary angiography/PCI it is recommended to withhold treatment for 48 h or until renal function has returned to its initial level.	<b>I</b>	<b>C</b>

# Guidance for Industry

## Diabetes Mellitus — Evaluating Cardiovascular Risk in New Antidiabetic Therapies to Treat Type 2 Diabetes

¿Ensayos Clínicos?

*Additional copies are available from:*

European Medicines Agency recommends  
suspension of Avandia, Avandamet and Avaglim

### Press release

23/09/2010



**European Medicines Agency recommends suspension of Avandia,  
Avandamet and Avaglim**

**Anti-diabetes medication to be taken off the market**

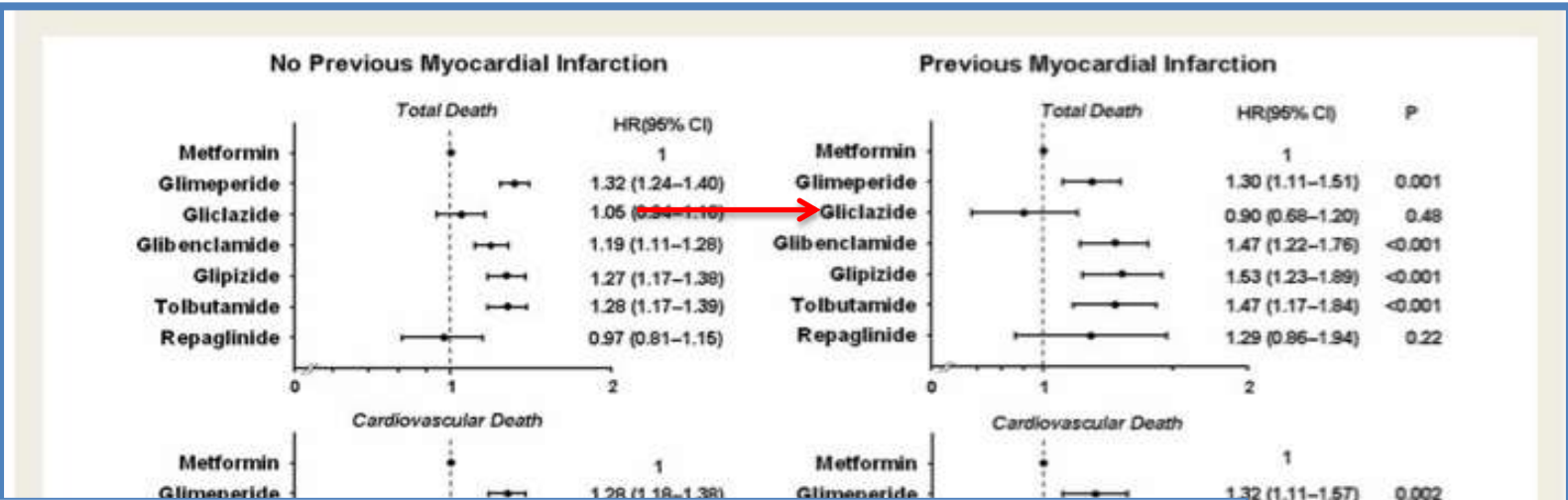
U.S. Department of Health and Human Services  
Food and Drug Administration  
Center for Drug Evaluation and Research (CDER)

December 2008  
Clinical/Medical





Mortality with different glucose-lowering agents without a previous myocardial infarction



ORIGINAL ARTICLE

# Intensive Blood Glucose Control and Vascular Outcomes in Patients with Type 2 Diabetes

The ADVANCE Collaborative Group

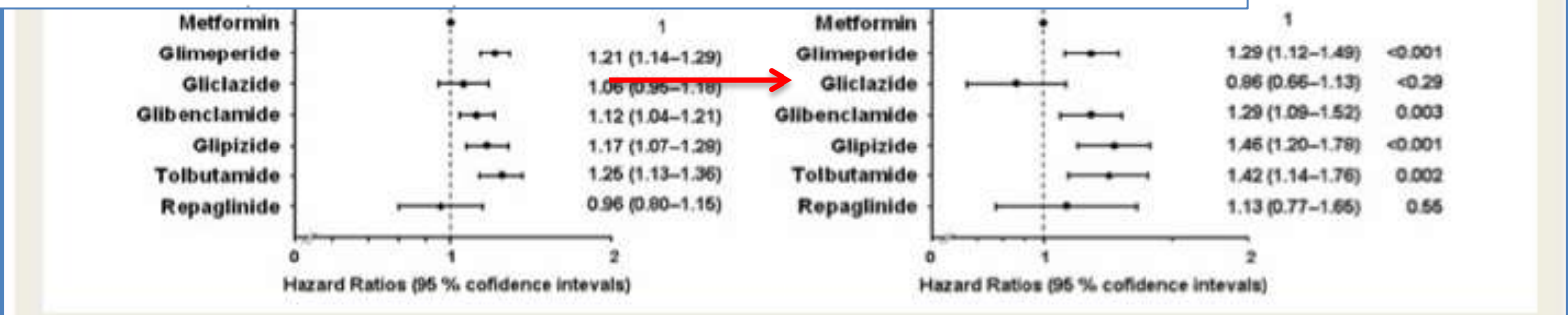


Figure 1 Hazard ratios (95% CI) for different endpoints in relation to monotherapies with different glucose-lowering agents according to previous myocardial infarction.



**1**

**Alogliptina no produce más eventos CV que placebo en pacientes DM2 + SCA reciente. ( Muerte CV, IM no fatal o Stroke no fatal)**

**Seguridad**

**2**

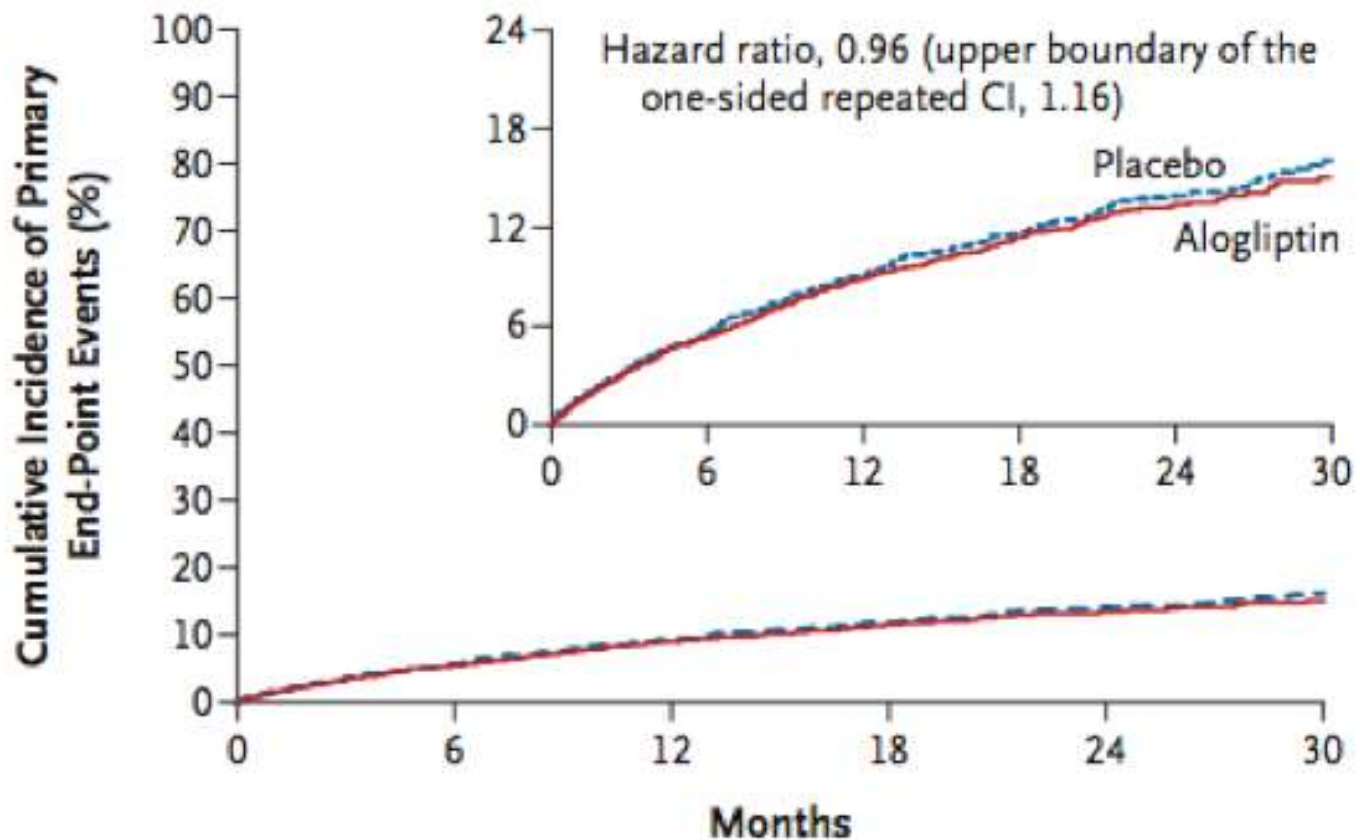
**Alogliptina es superior a placebo en la reducción de eventos CV en pacientes DM2 + SCA reciente. ( Muerte CV, IM no fatal, Stroke no fatal y revascularización urgente)**

**Eficacia**



Abbreviation: QD, once daily. <sup>a</sup> At randomization, patients were assigned to receive 25, 12.5, or 6.25 mg QD based on renal function. After randomization, dose adjustments were allowed on the basis of changes in renal function..

# Resultados



## No. at Risk

Placebo	2679	2299	1891	1375	805	286
Alogliptin	2701	2316	1899	1394	821	296

ORIGINAL ARTICLE

# Alogliptin after Acute Coronary Syndrome in Patients with Type 2 Diabetes

William B. White, M.D., Christopher P. Cannon, M.D., Simon R. Heller, M.D.,  
Steven E. Nissen, M.D., Richard M. Bergenstal, M.D., George L. Bakris, M.D.,  
Alfonso T. Perez, M.D., Penny R. Fleck, M.B.A., Cyrus R. Mehta, Ph.D.,  
Stuart Kupfer, M.D., Craig Wilson, Ph.D., William C. Cushman, M.D.,  
and Faiez Zannad, M.D., Ph.D., for the EXAMINE Investigators\*

## CONCLUSIONS

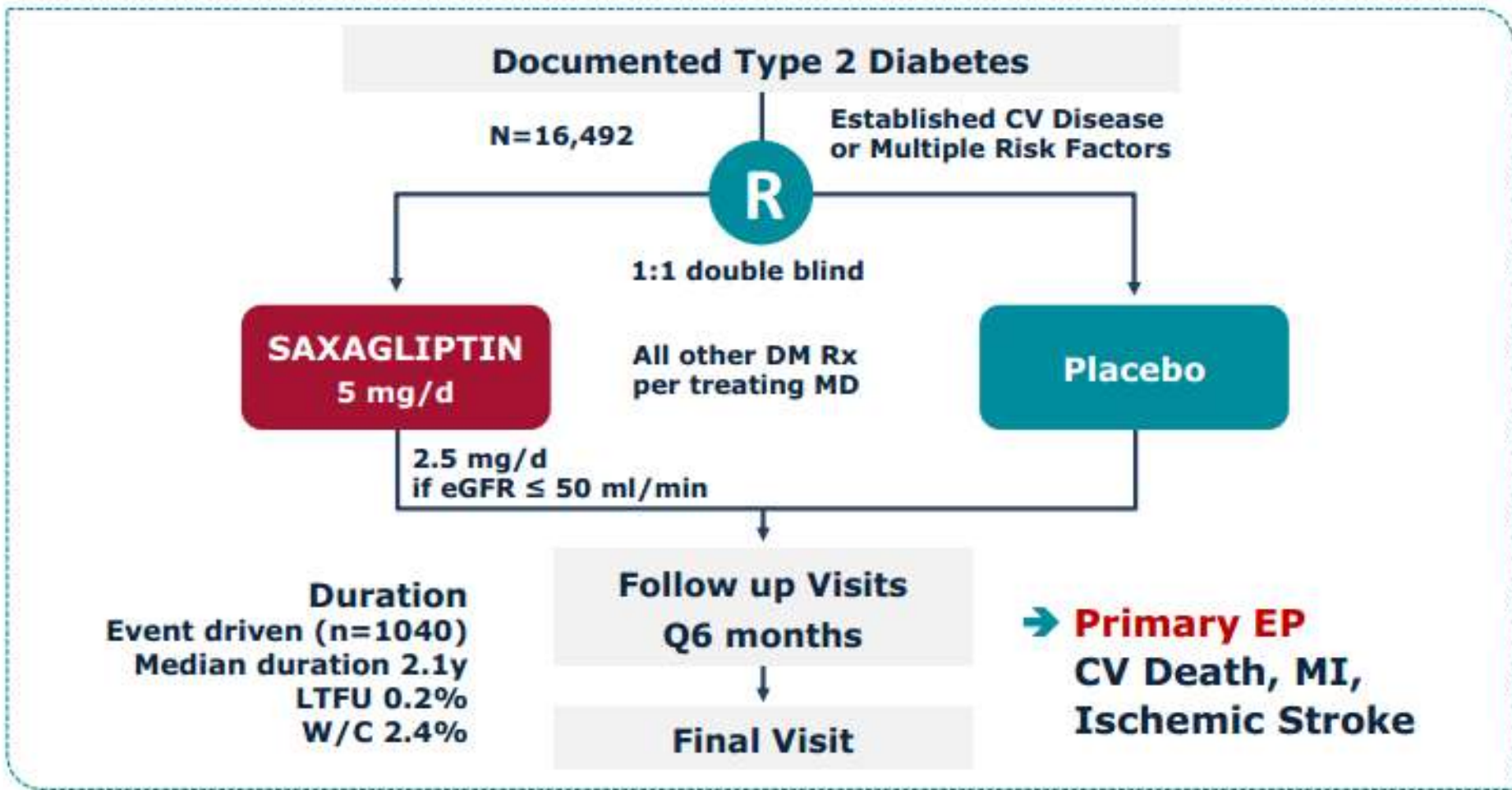
Seguridad: sí

Eficacia en reducción de eventos CV: NO

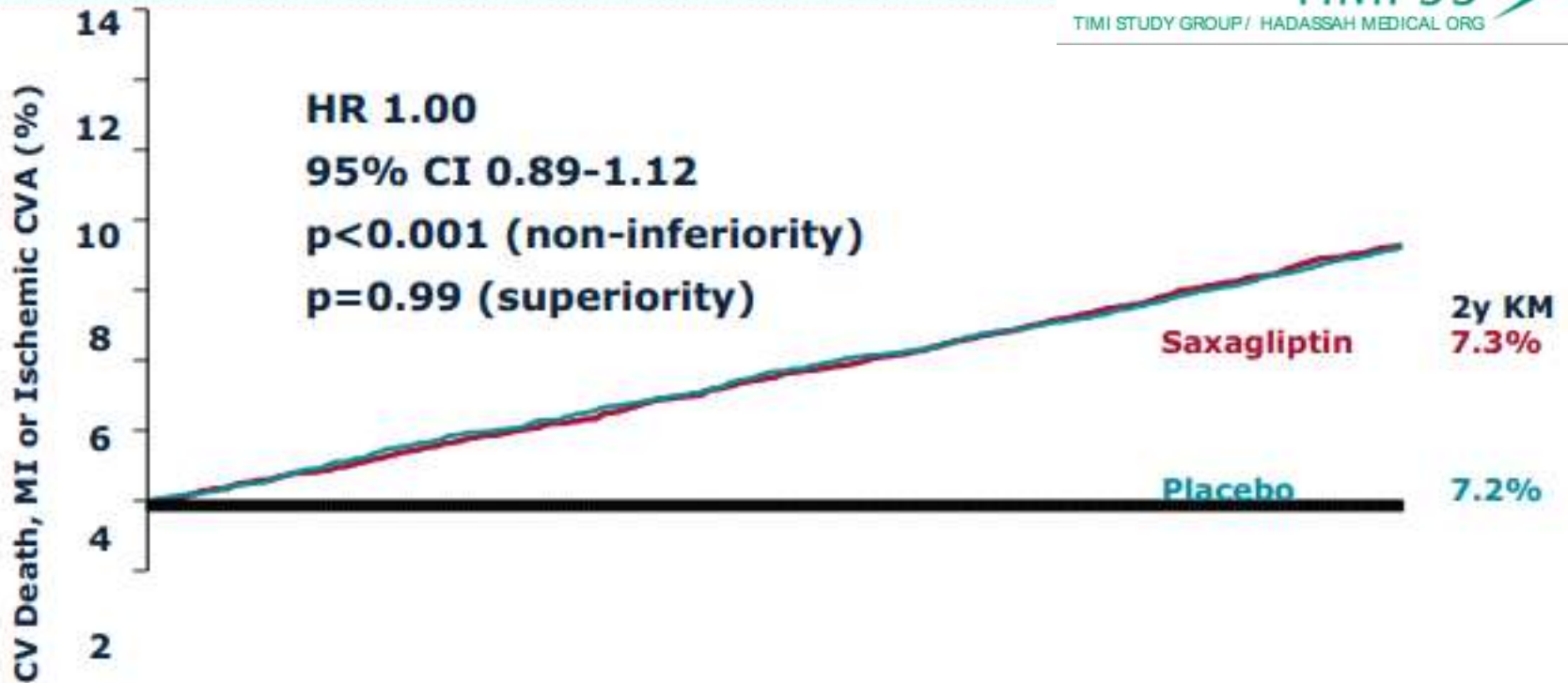
ORIGINAL ARTICLE

# Saxagliptin and Cardiovascular Outcomes in Patients with Type 2 Diabetes Mellitus

Benjamin M. Scirica, M.D., M.P.H., Deepak L. Bhatt, M.D., M.P.H., Eugene Braunwald, M.D., P. Gabriel Steg, M.D., Jaime Davidson, M.D., Boaz Hirshberg, M.D., Peter Ohman, M.D., Robert Frederich, M.D., Ph.D., Stephen D. Wiviott, M.D., Elaine B. Hoffman, Ph.D., Matthew A. Cavender, M.D., M.P.H., Jacob A. Udell, M.D., M.P.H., Nihar R. Desai, M.D., M.P.H., Ofri Mozenson, M.D., Darren K. McGuire, M.D., Kausik K. Ray, M.D., Lawrence A. Leiter, M.D., and Itamar Raz, M.D., for the SAVOR-TIMI 53 Steering Committee and Investigators\*



→ **Major Secondary EP:** CV death, MI, ischemic stroke, or hosp. for heart failure, unstable angina, or coronary revascularization



		6	12	18	24
Placebo	8212	7983	7761	7267	4855
Saxagliptin	8280	8071	7836	7313	4920

2-year KM rate (%)

	Placebo (N=8,212)	Saxagliptin (N=8,280)	HR	<i>p</i> value for superiority
CV Death	2.9	3.2	1.03 (0.87-1.22)	0.72
MI	3.4	3.2	0.95 (0.80-1.12)	0.52
Ischemic Stroke	1.7	1.9	1.11 (0.88-1.39)	0.38
Hosp for Cor. Revasc	5.6	5.2	0.91 (0.80-1.04)	0.18
Hosp for UA	1.0	1.2	1.19 (0.89-1.60)	0.24
Hosp for Heart Failure	2.8	3.5	1.27 (1.07-1.51)	0.007
All-Cause Mortality	4.2	4.9	1.11 (0.96-1.27)	0.15



## CONCLUSIONS

DPP-4 inhibition with saxagliptin did not increase or decrease the rate of ischemic events, though the rate of hospitalization for heart failure was increased. Although saxagliptin improves glycemic control, other approaches are necessary to reduce cardiovascular risk in patients with diabetes. (Funded by AstraZeneca and Bristol-Myers Squibb; SAVOR-TIMI 53 ClinicalTrials.gov number, NCT01107886.)

Seguridad: sí ( dudas en IC)

Eficacia en reducción de eventos CV: NO

# Hipoglucemia y Riesgo cardiovascular

European Heart Journal Advance Access published September 2, 2013



European Heart Journal  
doi:10.1093/eurheartj/eh332

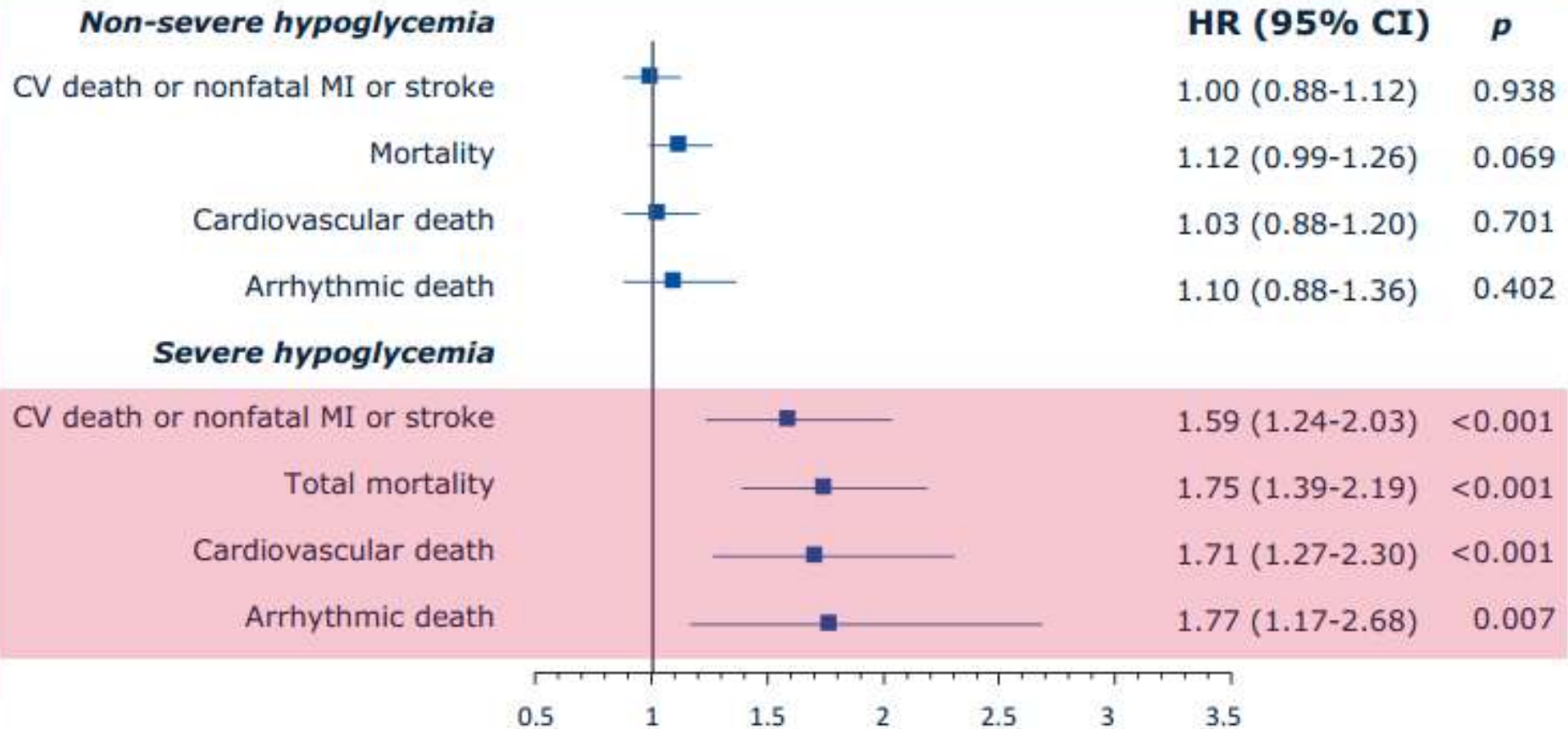
**FASTTRACK CLINICAL RESEARCH**

*Disease management*

## Does hypoglycaemia increase the risk of cardiovascular events? A report from the **ORIGIN** trial

The **ORIGIN** Trial Investigators\*†

# Resultados



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- **Guías Práctica Clínica**
- **Simplicity HTN1**

## 2013 ESH/ESC Guidelines for the management of arterial hypertension

The Task Force for the Management of Arterial Hypertension of the European Society of Cardiology

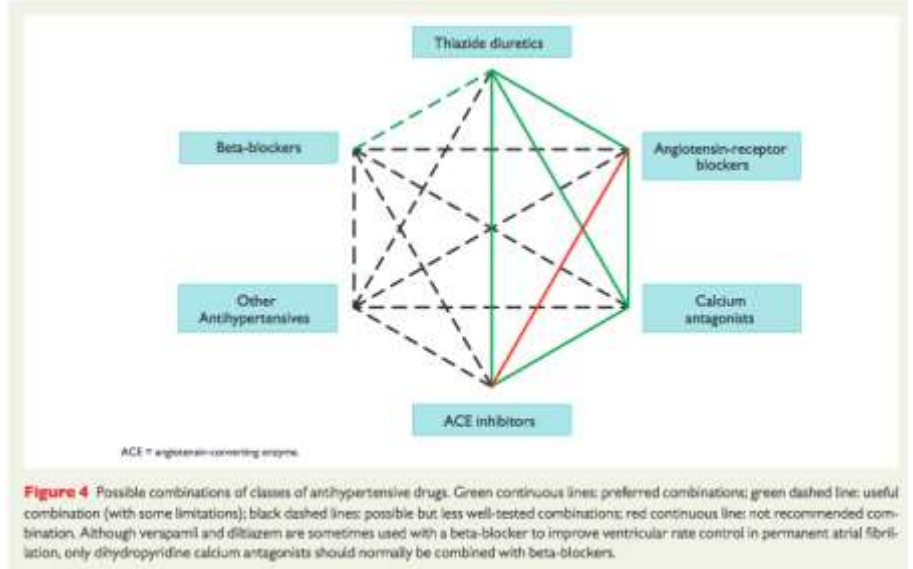
OBJETIVO < 140/90

DM < 140/85

Proteinuria < 130 TAS

- **Importancia medición de la TA ambulatoria**

- **Elección Fármaco:**



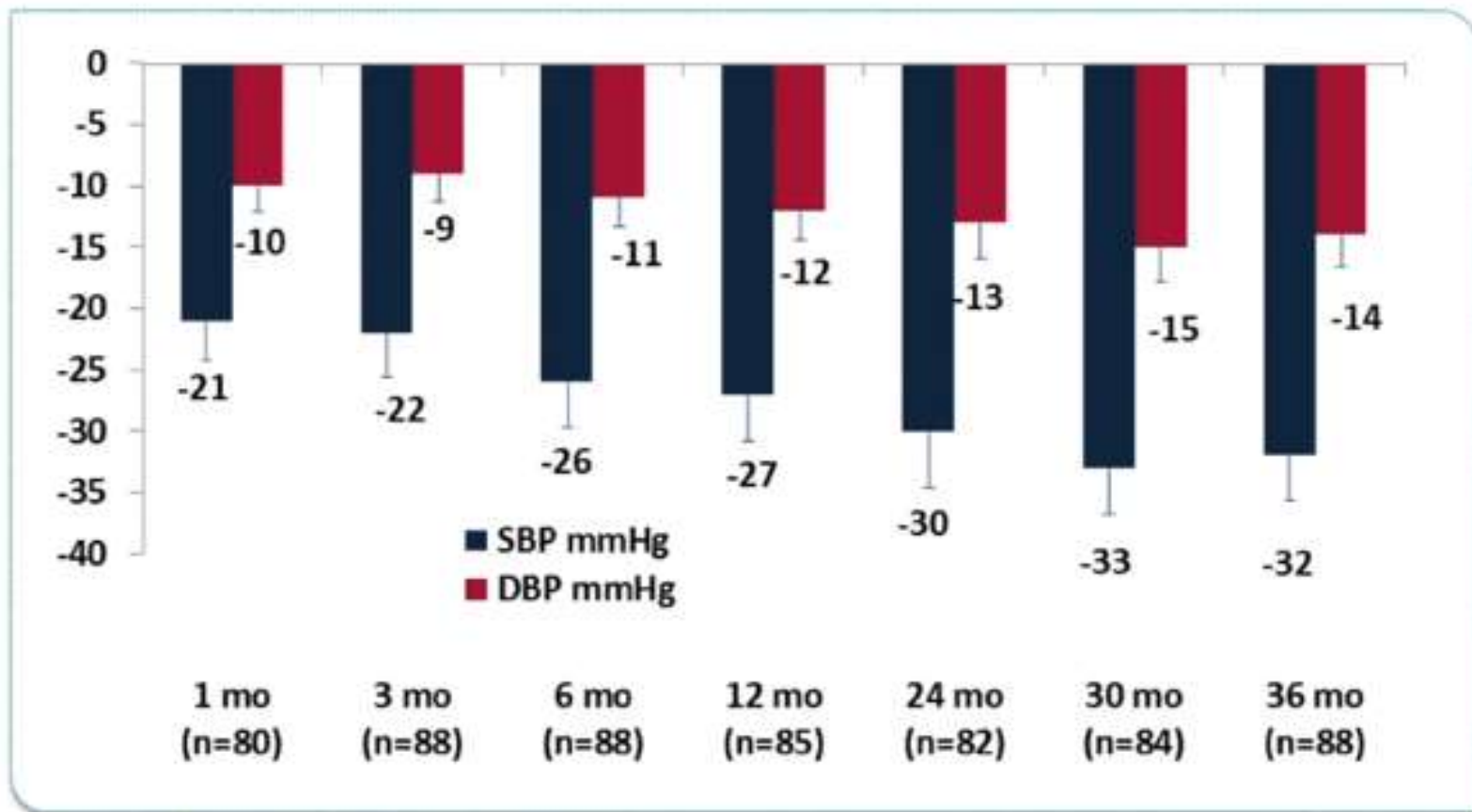
- **Monoterapia o terapia combinada:**

Recommendations	Class <sup>a</sup>	Level <sup>b</sup>
Diuretics (thiazides, chlorthalidone and indapamide), beta-blockers, calcium antagonists, ACE inhibitors, and angiotensin receptor blockers are all suitable and recommended for the initiation and maintenance of antihypertensive treatment, either as monotherapy or in some combinations with each other.	I	A

The combination of two antagonists of the RAS is not recommended and should be discouraged.

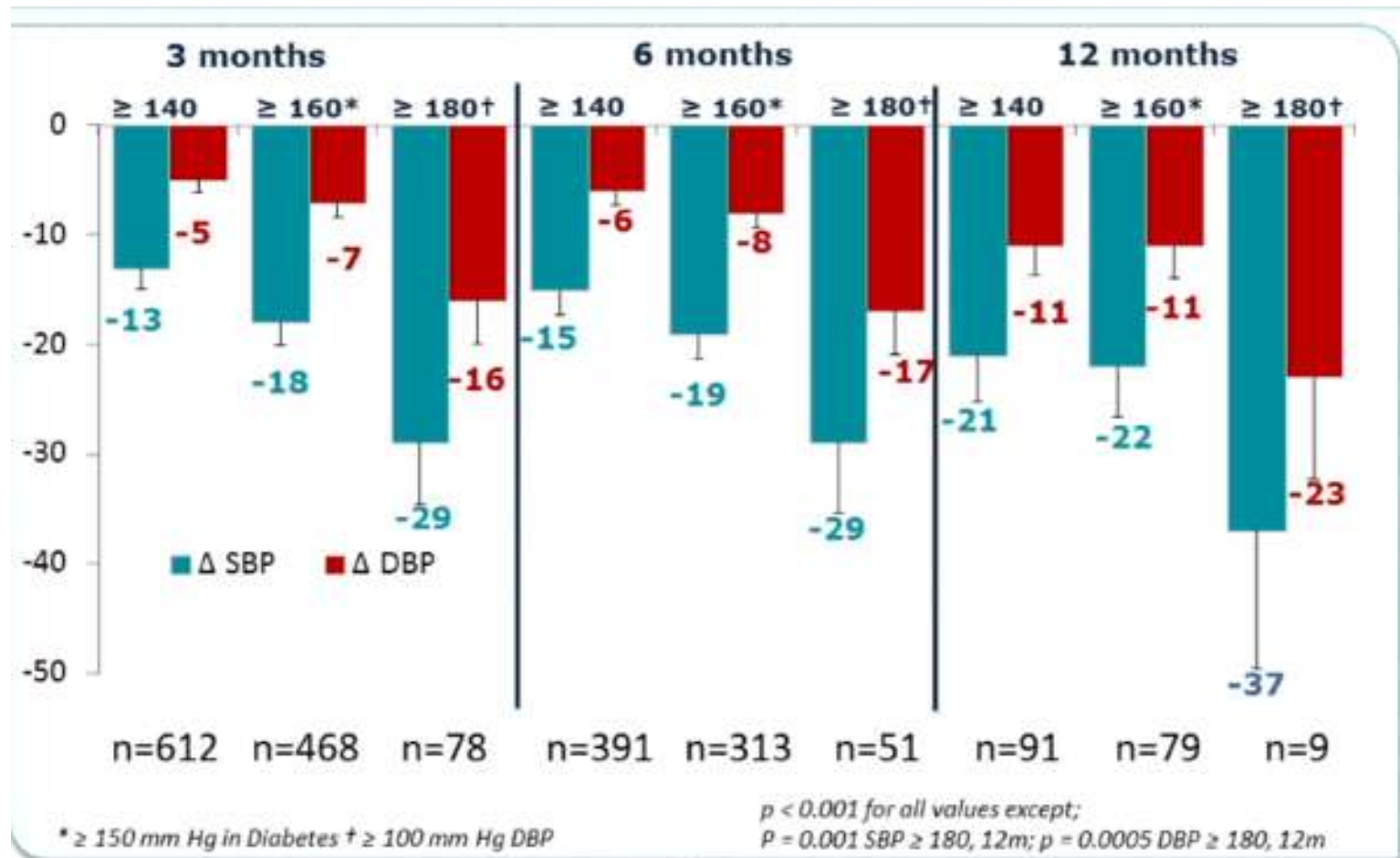
III	A
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# Symlicity HTN-1: cifras TA en consulta



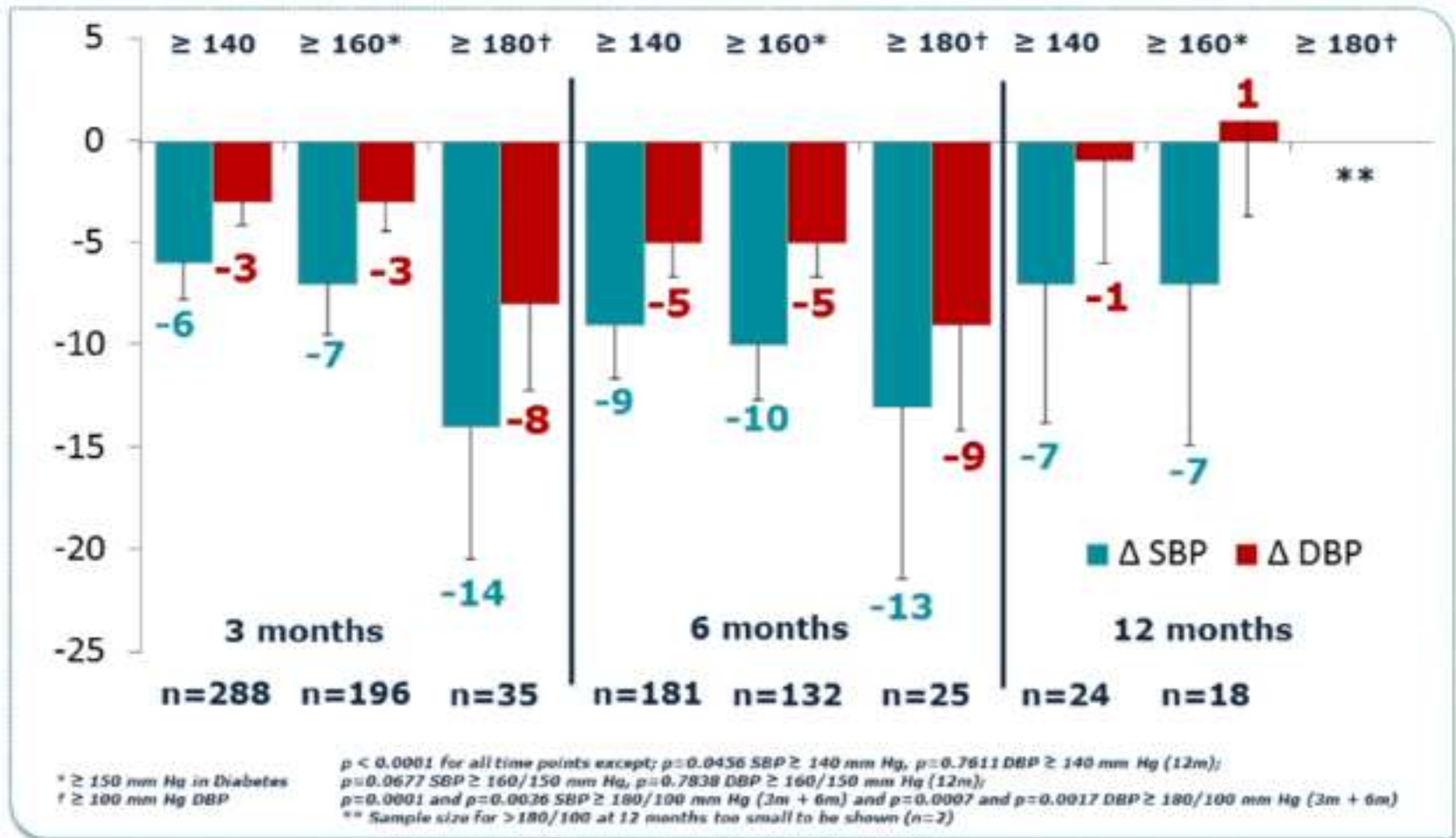
P<0.01 for Δ from BL for all time points

# Registro Symplicity : cifras TA en consulta





# Registro Symplicity : MAPA



# CONCLUSIONES

## 1. Prevención:

- El impacto de FRCV es diferente según el E. Social
- No se cumplen objetivos de las GPC en P. 2 daria
- El cumplimiento de las GPC= Aumento Supervivencia

## 2. DM:

- HA1C < 7% ( individualizar)
- Tto multifactorial: estilo de vida +LDL + TA+ AA P2
- IDPP-4: Fallan en la reducción de eventos CV

## 3. HTA

- <140/80 - <140/85 DM y < 130 TAS proteinuria
- Denervación renal:eficaz (dudas control ambulatorio)