TRATAMIENTO DEL SINDROME ANTIFOSFOLIPIDO

certezas y dudas

galsu
gurutzetako autoinmune sistemikoen ikerketa unitatea

eman ta zabal zazu

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EHU / UPV


DÉJÀVU
NOW PLAYING!

How I treat the antiphospholipid syndrome

BLOOD, 3 SEPTEMBER 2009 • VOLUME 114, NUMBER 10

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BMJ | 22 MAY 2010 | VOLUME 340

CLINICAL REVIEW

Diagnosis and management of the antiphospholipid syndrome

Danielle Cohen,[1] Stefan P Berger,[2] Gerda M Steup-Beekman,[3] Kitty W M Bloemenkamp,[4] Ingeborg M Bajema[1]

Lupus (2010) 19, 470–474
http://lup.sagepub.com

REVIEW

Towards evidence-based treatment of thrombotic antiphospholipid syndrome

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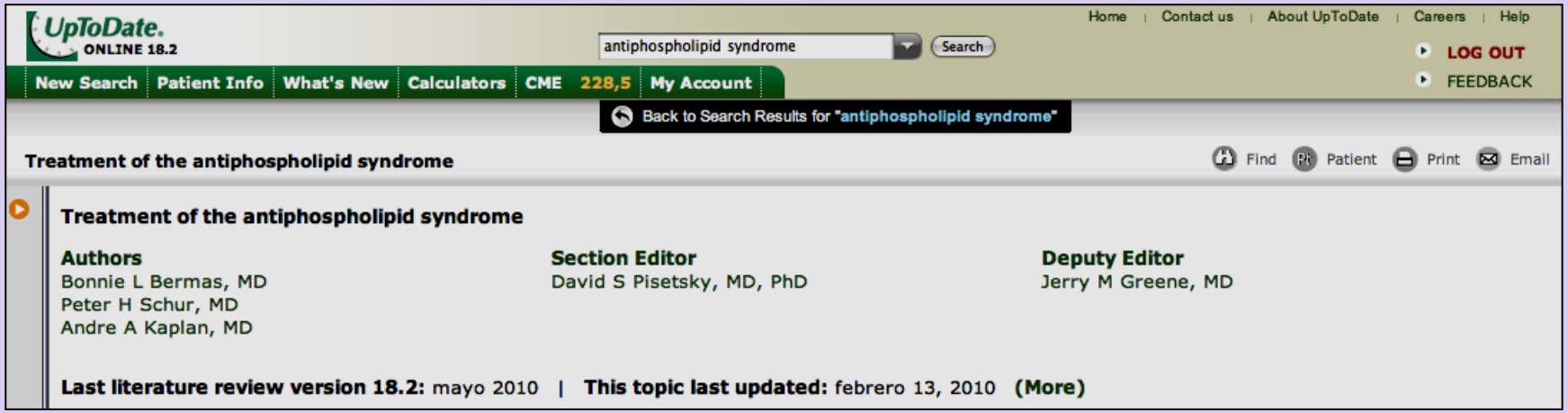
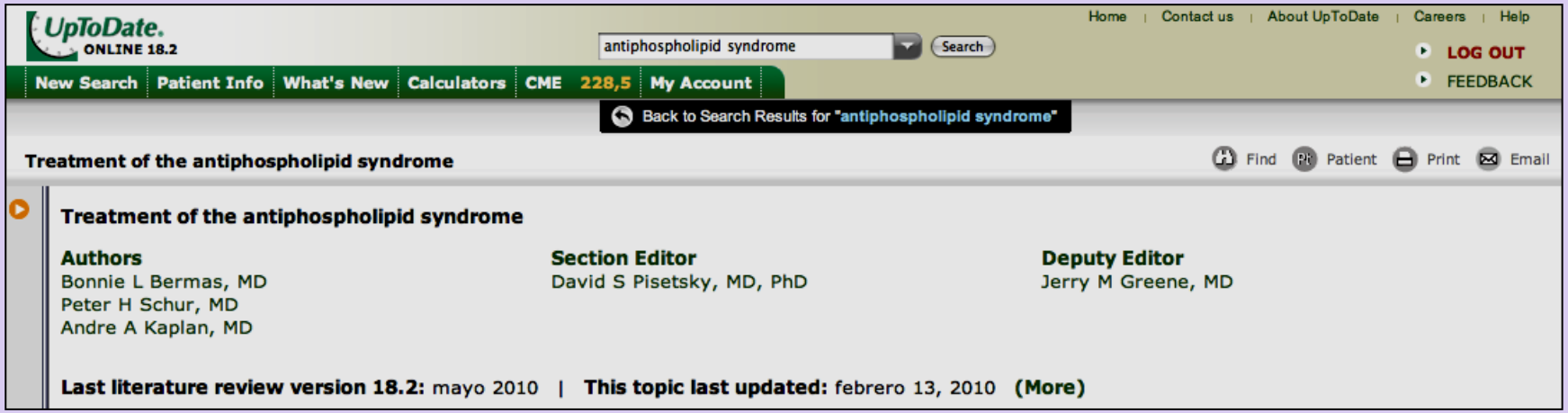
www.thelancet.com Published online September 6, 2010

Antiphospholipid syndrome

Guillermo Ruiz-Irastorza, Mark Crowther, Ware Branch, Munther A Khamashta



However, the current standard of care for the long-term management of the APS is to maintain the INR between 2.0 and 3.0 for an initial venous thromboembolic event and at >3.0 for an initial arterial event or for recurrent venous thrombosis despite anticoagulation



However, the current standard of care for the long-term management of the APS is to maintain the INR between 2.0 and 3.0 for an initial venous thromboembolic event and at >3.0 for an initial arterial event or for recurrent venous thrombosis despite anticoagulation.

Thus, high-intensity therapy is associated with no demonstrable benefit and potential harm. The current standard of care for the long-term management of the APS is to maintain the INR between 2.0 and 3.0.

LAS CUESTIONES CLAVE

Arterial igual que venoso?

Intensidad de anticoagulación?

Papel de la antiagregación?

Tromboprofilaxis primaria?

EVIDENCE-BASED RECOMMENDATIONS FOR THE PREVENTION AND LONG-TERM MANAGEMENT OF THROMBOSIS IN ANTIPHOSPHOLIPID ANTIBODY POSITIVE PATIENTS.

REPORT OF A TASK FORCE AT THE 13TH INTERNATIONAL CONGRESS ON ANTIPHOSPHOLIPID ANTIBODIES.

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Lupus 2010 (in press)

EVALUANDO LA EVIDENCIA

Guyatt GH, et al. Grades of recommendation for antithrombotic agents: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Chest 2008; 133: 123S-131S

1: Recomendación fuerte. Beneficio >> Riesgo

2: Recomendación débil. Beneficio ??? Riesgo

A: Evidencia de alta calidad

B: Evidencia de calidad media

C: Evidencia de baja o muy baja calidad

PERFILES DE RIESGO

aFL alto riesgo:

- **AL**
- **Triple positivos**
- **aCL niveles medio-altos persistentemente positivos**

aFL bajo riesgo:

- **aCL o anti-ß2 GPI aislados, niveles medio-bajos, intermitentes**

Otros factores de riesgo:

- **LES**
- **Tabaco, HTA, DM, dislipemia, estrógenos**
- **Manifestaciones SAF no trombóticas (livedo, trombopenia..)???**

RECURRENCIAS

Mayor riesgo de recidivas arteriales

Alta prevalencia de factores de riesgo clásicos

Pocas recurrencias documentadas con INR > 3.0

Alta incidencia de recidivas en pacientes de alto riesgo TRATADOS

Baja frecuencia de sangrados graves

Muertes por trombosis >>> muertes por sangrado

TRATAMIENTO

+
intervención

-
intervención

GENERAL MEASURES FOR APL-CARRIERS

1.1.- A strict control of cardiovascular risk factors should be accomplished in all individuals with a high-risk aPL profile, irrespective of the presence of previous thrombosis, concomitant SLE or additional APS features.

NON GRADED

1.2.- We recommend that all aPL carriers receive thromboprophylaxis with usual doses of low-molecular weight heparin in high-risk situations, such as surgery, prolonged immobilization and the puerperium.

1C

PRIMARY THROMBOPROPHYLAXIS IN SLE PATIENTS WITH APL

2.1.- Clinicians should regularly assess patients with SLE for the presence of aPL.

NON GRADED

2.2.- We recommend that patients with SLE and positive LA or isolated persistent aCL at medium-high titres receive primary thromboprophylaxis with hydroxychloroquine (1) and low-dose aspirin (2).

1B (1)

2B (2)

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1B (1)

2B (2)

Note: Some members of the Task Force (DE, RD, SK, VP) suggest hydroxychloroquine use in this setting with a grade **2B**.

PRIMARY THROMBOPROPHYLAXIS IN APL-POSITIVE INDIVIDUALS WITHOUT SLE

3.1.- In non-SLE individuals with aPL and no previous thrombosis, we suggest long-term primary thromboprophylaxis with low-dose aspirin in those with a high-risk aPL profile, especially in the presence of other thrombotic risk factors.

2C

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SECONDARY THROMBOPROPHYLAXIS (I)

4.1.- We recommend that patients with either arterial or venous thrombosis and aPL who do not fulfil criteria for APS be managed in the same manner as aPL-negative patients with similar thrombotic events.

1C

4.2.- We recommend that patients with definite APS and a first venous event receive oral anticoagulant therapy to a target INR 2.0-3.0.

1B

SECONDARY THROMBOPROPHYLAXIS (II)

4.3- Patients with definite APS and arterial thrombosis should be treated with warfarin at an INR >3.0 or combined antiaggregant-anticoagulant (INR 2.0-3.0) therapy.

NON GRADED DUE TO LACK OF CONSENSUS

SECONDARY THROMBOPROPHYLAXIS (II)

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NON GRADED DUE TO LACK OF CONSENSUS

Note: Some members of the Task Force (MC, DE, RD, SK, VP) believe that other options such as antiaggregant therapy alone or anticoagulant therapy to a target INR 2.0-3.0 would be equally valid in this setting.

SECONDARY THROMBOPROPHYLAXIS (II)

4.3- Patients with definite APS and arterial thrombosis should be treated with warfarin at an INR >3.0 or combined antiaggregant-anticoagulant (INR 2.0-3.0) therapy.

NON GRADED DUE TO LACK OF CONSENSUS

4.4.- An estimation of the patients' bleeding risk should be performed before prescribing high intensity anticoagulant or combined antiaggregant-anticoagulant therapy..

NON GRADED

SECONDARY THROMBOPROPHYLAXIS (III)

4.5.- Non SLE patients with a first non-cardioembolic cerebral arterial event, with a low-risk aPL profile and the presence of reversible trigger factors could individually be considered candidates to treatment with antiplatelet agents.

NON GRADED

DURATION OF TREATMENT

5.1.- We recommend indefinite antithrombotic therapy in patients with definite APS and thrombosis.

1C

5.2.- In cases of first venous event, low-risk aPL profile and a known transient precipitating factor, anticoagulation could be limited to 3 to 6 months..

NON GRADED

REFRACTORY AND DIFFICULT CASES

6.1.- In patients with difficult management due to recurrent thrombosis, fluctuating INR levels, major bleeding or at a high risk for major bleeding, alternative therapies could include long-term low-molecular weight heparin, hydroxychloroquine or statins.

NON GRADED

LO MALO

En general, baja calidad de evidencia

Alto porcentaje (50%) de recomendaciones “non graded”

Falta de consenso en algunas recomendaciones:

- **HCQ en LES con aFL**
- **Tromboprofilaxis secundaria de trombosis arteriales**

LO BUENO

Amplio nivel de consenso multidisciplinar:

- **4 internistas**
- **4 reumatólogos**
- **2 hematólogos**
- **1 neuróloga**
- **1 cardiólogo**
- **1 bioquímica**

LO NUEVO

Definición de perfiles de riesgo:

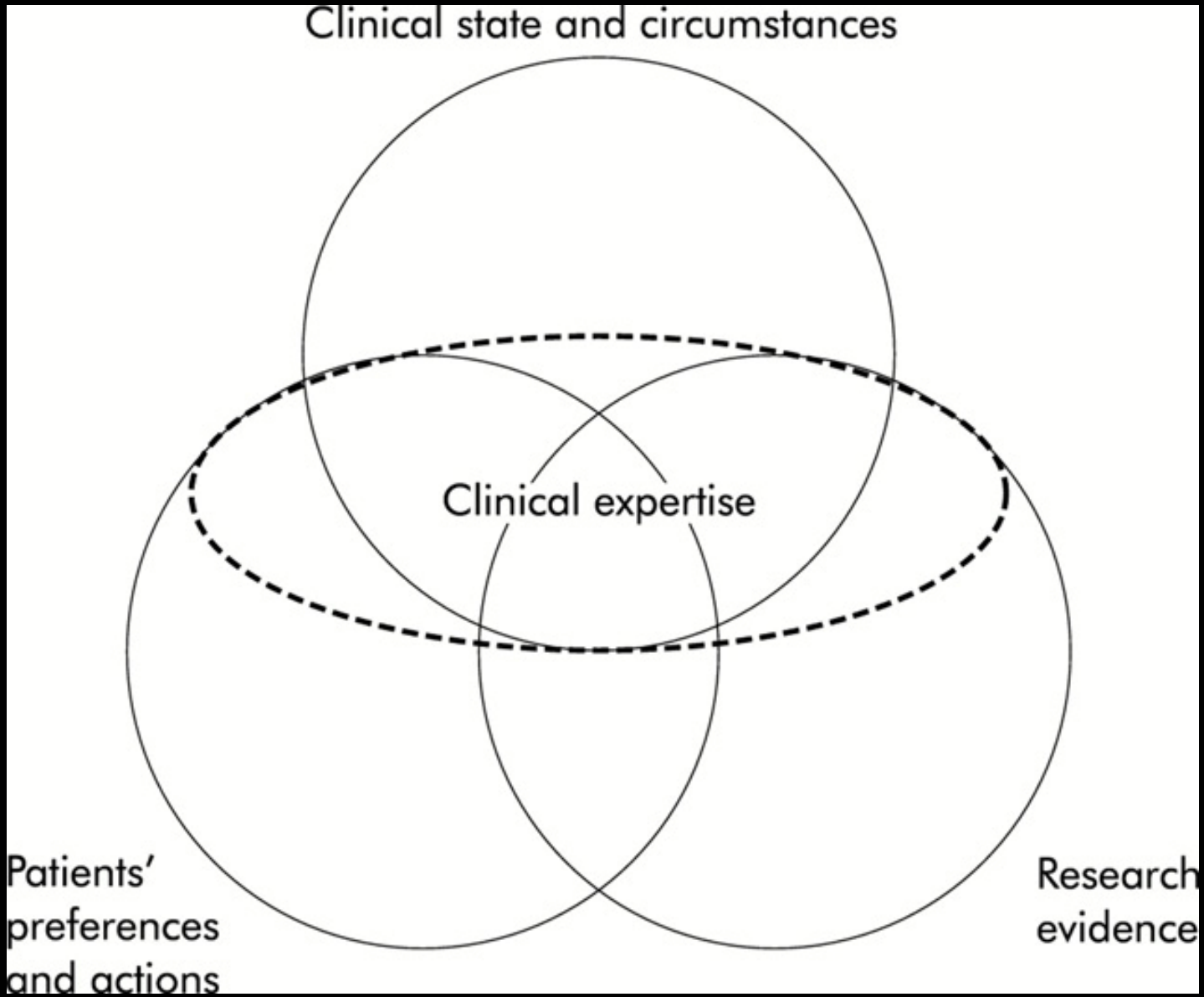
- **Más anticuerpos = Más riesgo**
- **Lupus**
- **Factores clásicos**

Relajación de intensidad de tratamiento en perfiles de bajo riesgo

- **Antiagregación en arterial**
- **Duración limitada en venosa**

RECOMENDACIONES.....

....NO MANDAMIENTOS


Clinical state and circumstances
Clinical expertise
Patients' preferences and actions
Research evidence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