Lo más importante de Cardiología en 2010

Dr. Vicente Bertomeu Martínez
Servicio de Cardiología
Hospital Universitario de San Juan. Alicante

Lo más importante de la cardiología en 2010

- Hipertensión Arterial
- Cardiopatía Isquémica
- Insuficiencia Cardiaca
- Arritmias
- Intervencionismo Percutáneo

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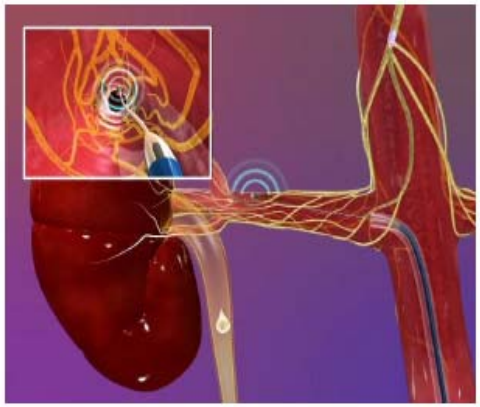
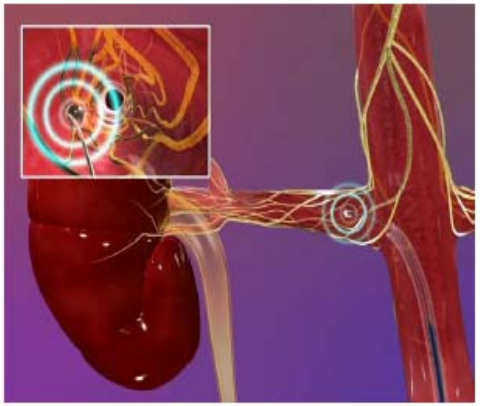
Devices in Hypertension. BP changes with renal sympathetic denervation in patients with refractory HT

Radio frequency ablation

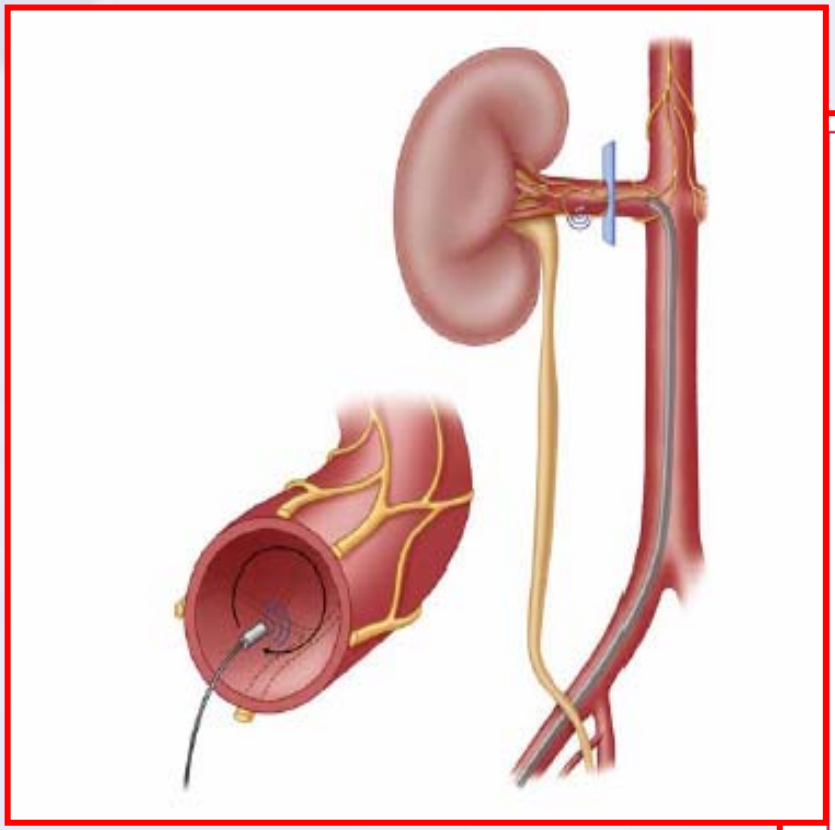


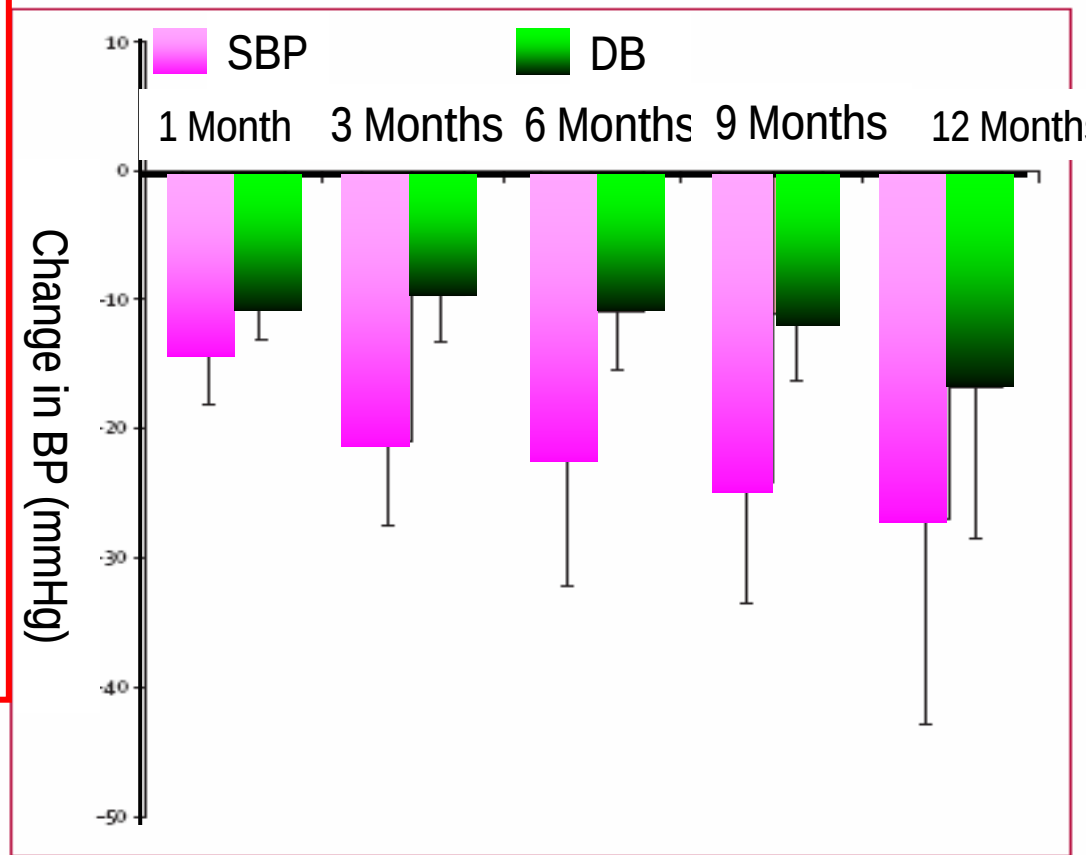


- Diameter >4 mm
- Length >20 mm
- 5 F LIMA or RDC guiding catheter

Late Trials ESC 2010

Devices in Hypertension. BP changes with renal sympathetic denervation in patients with refractory HT

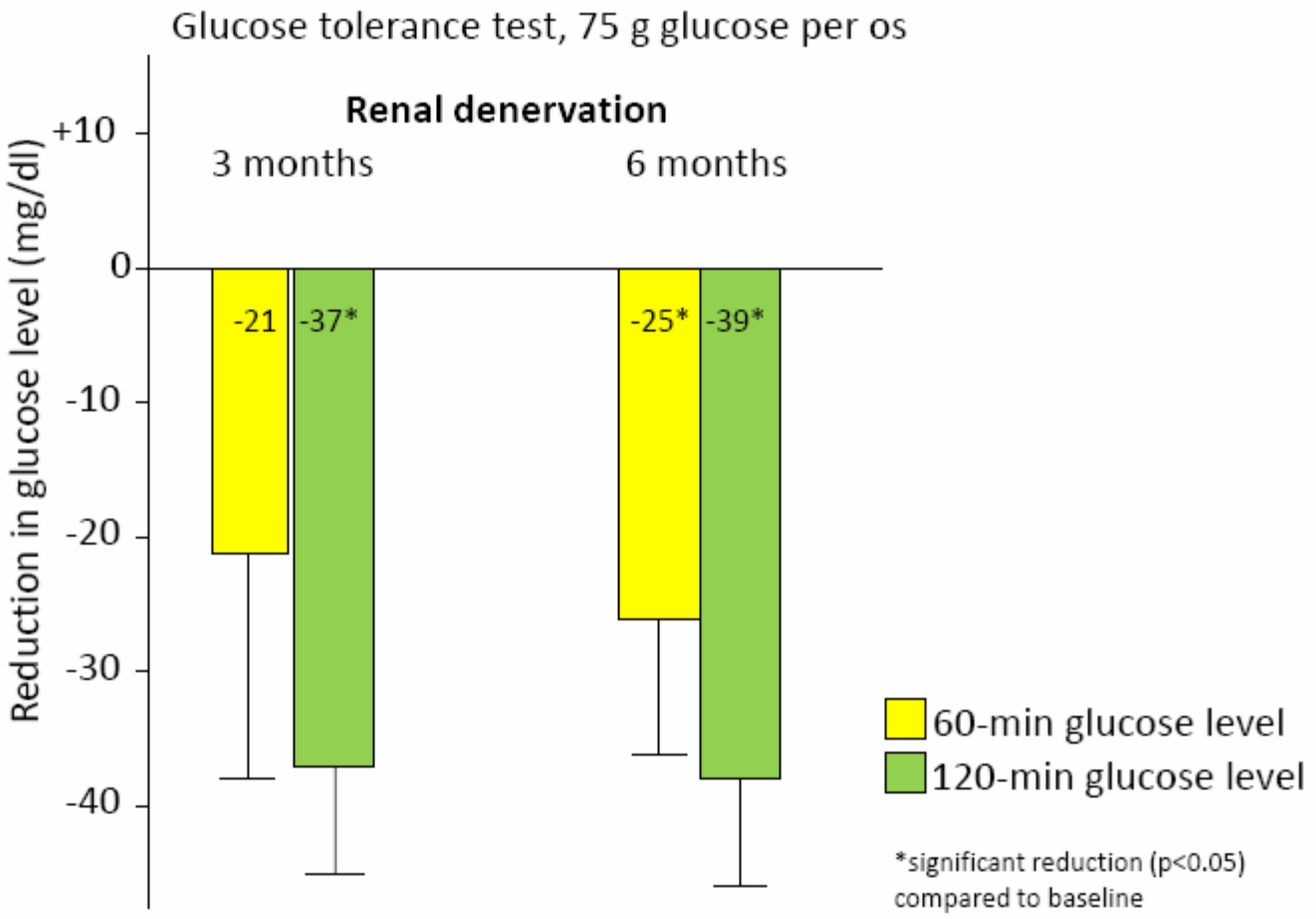




Late Trials ESC 2010

Devices in Hypertension.

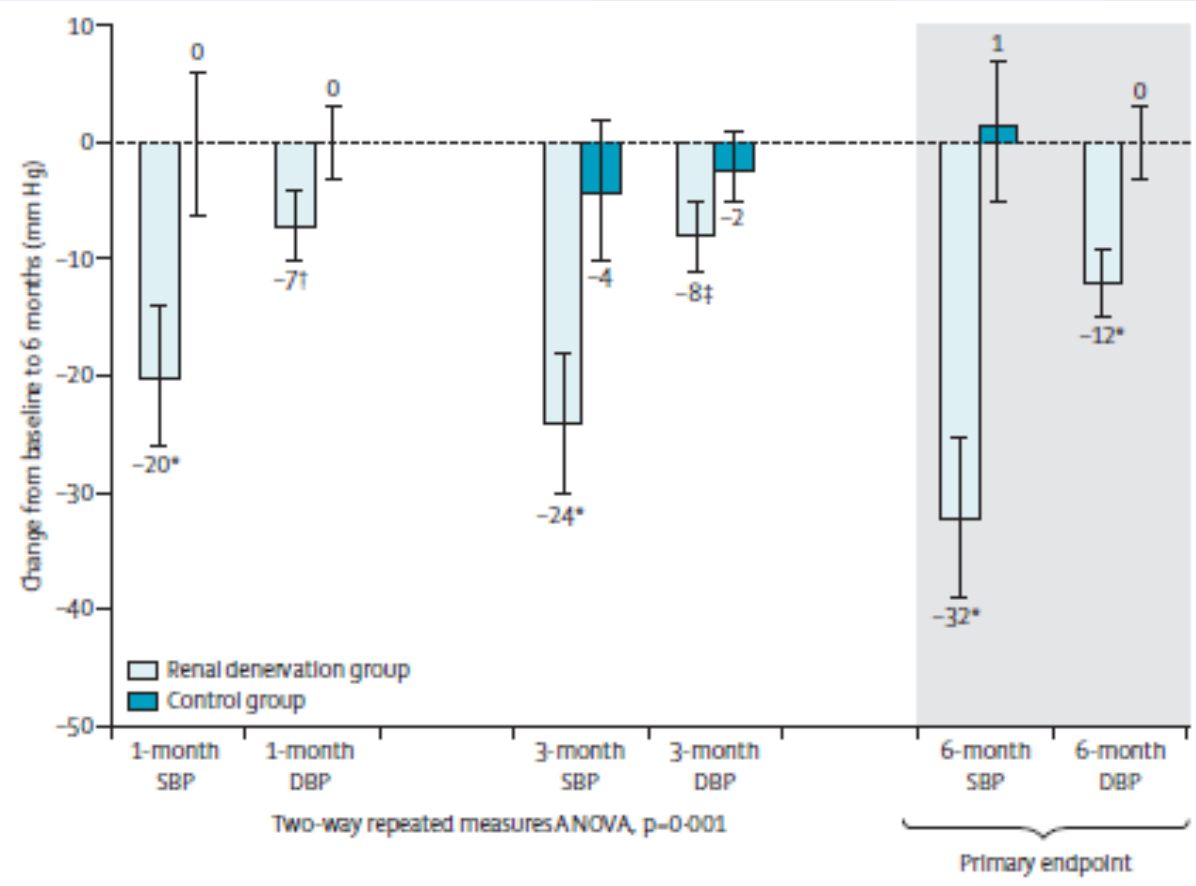
Renal denervation improves glucose tolerance



Late Trials ESC 2010

Renal sympathetic denervation in patients with treatment-resistant hypertension (The Symplicity HTN-2 Trial): a randomised controlled trial

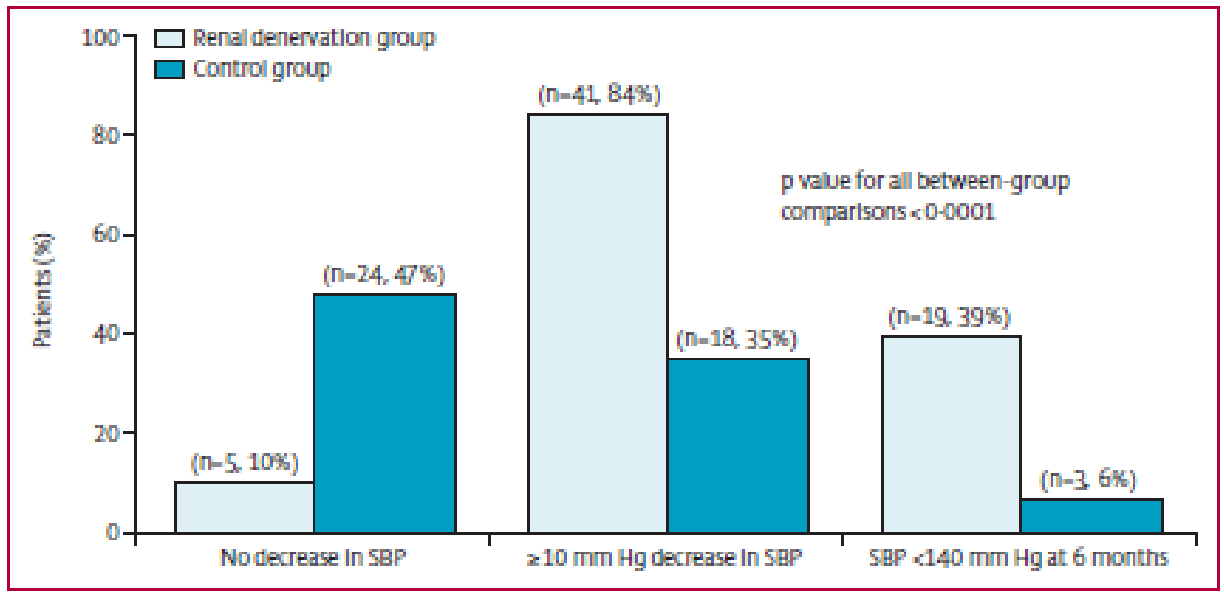
*Symplicity HTN-2 Investigators**



Late Trials AHA 2010
Lancet on line 2010

Renal sympathetic denervation in patients with treatment-resistant hypertension (The Symplicity HTN-2 Trial): a randomised controlled trial

*Symplicity HTN-2 Investigators**



Late Trials AHA 2010
Lancet on line 2010

Lo más importante de la cardiología en 2010

- Hipertensión Arterial
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- Intervencionismo Percutáneo

European Heart Journal
doi:10.1093/eurheartj/ehq277

ESC/EACTS GUIDELINES

GUIAS DE REVASCULARIZACIÓN MIOCÁRDICA

The Task Force on Myocardial Revascularization of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS)

Developed with the special contribution of the European Association for Percutaneous Cardiovascular Interventions (EAPCI)†

Authors/Task Force Members: William Wijns (Chairperson) (Belgium)*, Philippe Kolh (Chairperson) (Belgium)*, Nicolas Danchin (France), Carlo Di Mario (UK), Volkmar Falk (Switzerland), Thierry Folliguet (France), Scot Garg (The Netherlands), Kurt Huber (Austria), Stefan James (Sweden), Juhani Knuuti (Finland), Jose Lopez-Sendon (Spain), Jean Marco (France), Lorenzo Menicanti (Italy) Miodrag Ostojic (Serbia), Massimo F. Piepoli (Italy), Charles Pirlet (Belgium), Jose L. Pomar (Spain), Nicolaus Reifart (Germany), Flavio L. Ribichini (Italy), Martin J. Schalij (The Netherlands), Paul Sergeant (Belgium), Patrick W. Serruys (The Netherlands), Sigmund Silber (Germany), Miguel Sousa Uva (Portugal),

Associations: Heart Failure Association (HFA), European Association for Cardiovascular Prevention and Rehabilitation (EACPR), European Heart Rhythm Association (EHRA), European Association of Echocardiography (EAE).
Working Groups: Acute Cardiac Care, Cardiovascular Surgery, Thrombosis, Cardiovascular Pharmacology and Drug Therapy.
Councils: Cardiovascular Imaging, Cardiology Practice.

Nuevas Guías de la SEC: Revascularización Miocárdica

- Aproximación a la mejor estrategia de tratamiento en un determinado contexto social y cultural
- Qué pacientes se benefician más
- Concepto del **"*HEART TEAM*"**
- Mayor discusión entre los médicos-cirujanos implicados
- Más tiempo entre el momento del diagnóstico y la intervención (PCI ó CABG)
- Mas transparencia, mejor información y mayor participación del paciente
- Individualiza las indicaciones en función de la presentación y la patología asociada

CONCEPTO DE PRECONDICIONAMIENTO REMOTO

Local remote

Occlusion of CX
Infarct size in LAD

Przyklenk K et al. Circulation 1993;87:893-9

Distant remote

Four cycles of 5 minutes of upper limb ischemia induced by blood pressure cuff inflation (200 mm Hg)

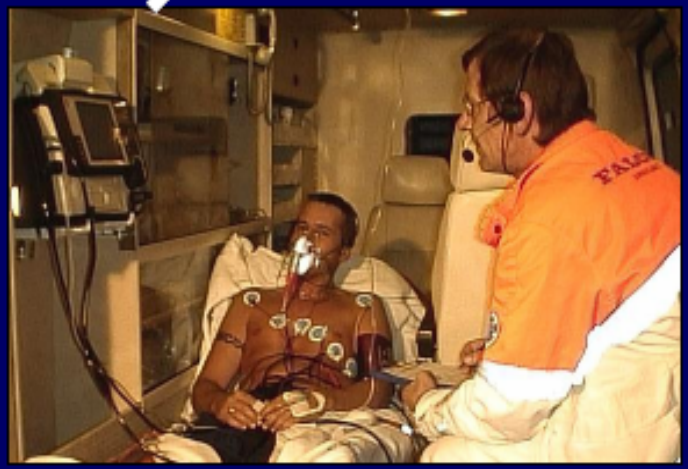
Kharbanda R et al. Circulation 2002;106:2881-3

PRECONDICIONAMIENTO DURANTE EL TRASLADO PARA LA PCI

	PCI only (n=125)	rIPerC (n=126)	P Value
Age, year (mean)	62±12	63±12	0.71
Male sex (%)	75	77	0.71
Diabetes Mellitus (%)	9	9	0.97
Current smoker (%)	57	56	0.67
Hypertension (%)	31	39	0.01
Statin Tx (%)	20	16	0.47
Symptom to balloon time, min (median [IQR])	185 [134; 309]	188 [132; 302]	0.98

ECG

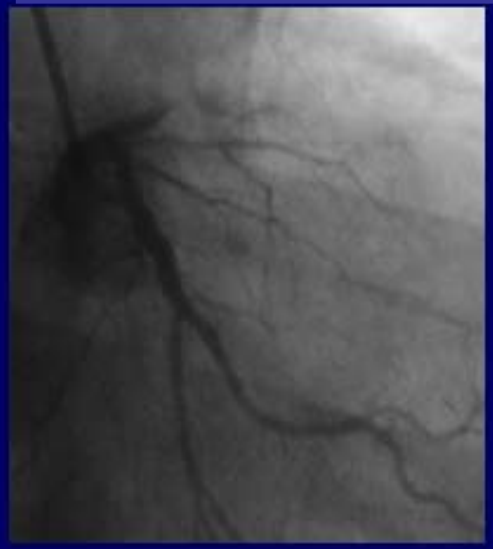
Randomization

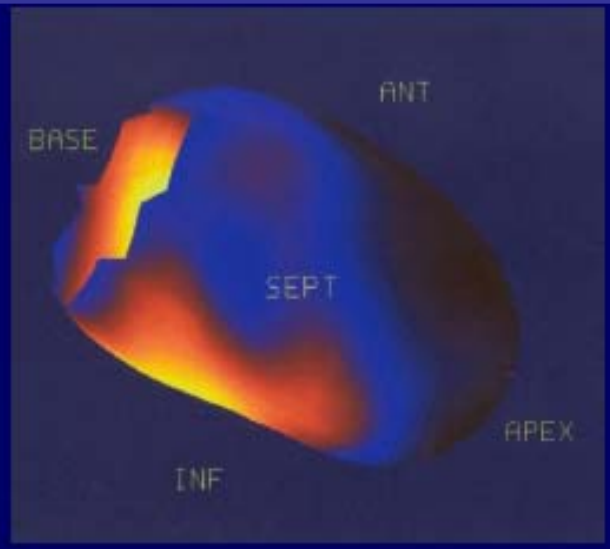


Patient

Ambulance

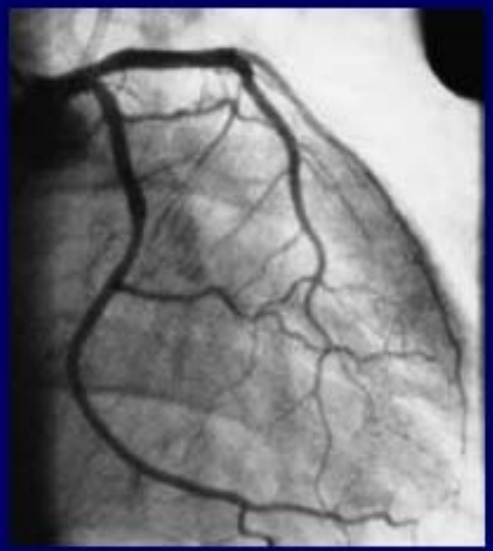
OBJETIVO PRIMARIO: INDICE DE MIOCARDIO SALVADO

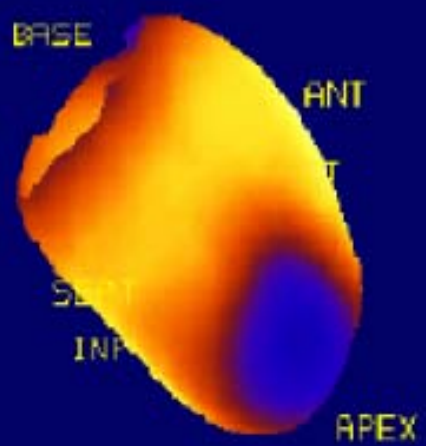




Acute scan:
Area-at-risk
(AAR)

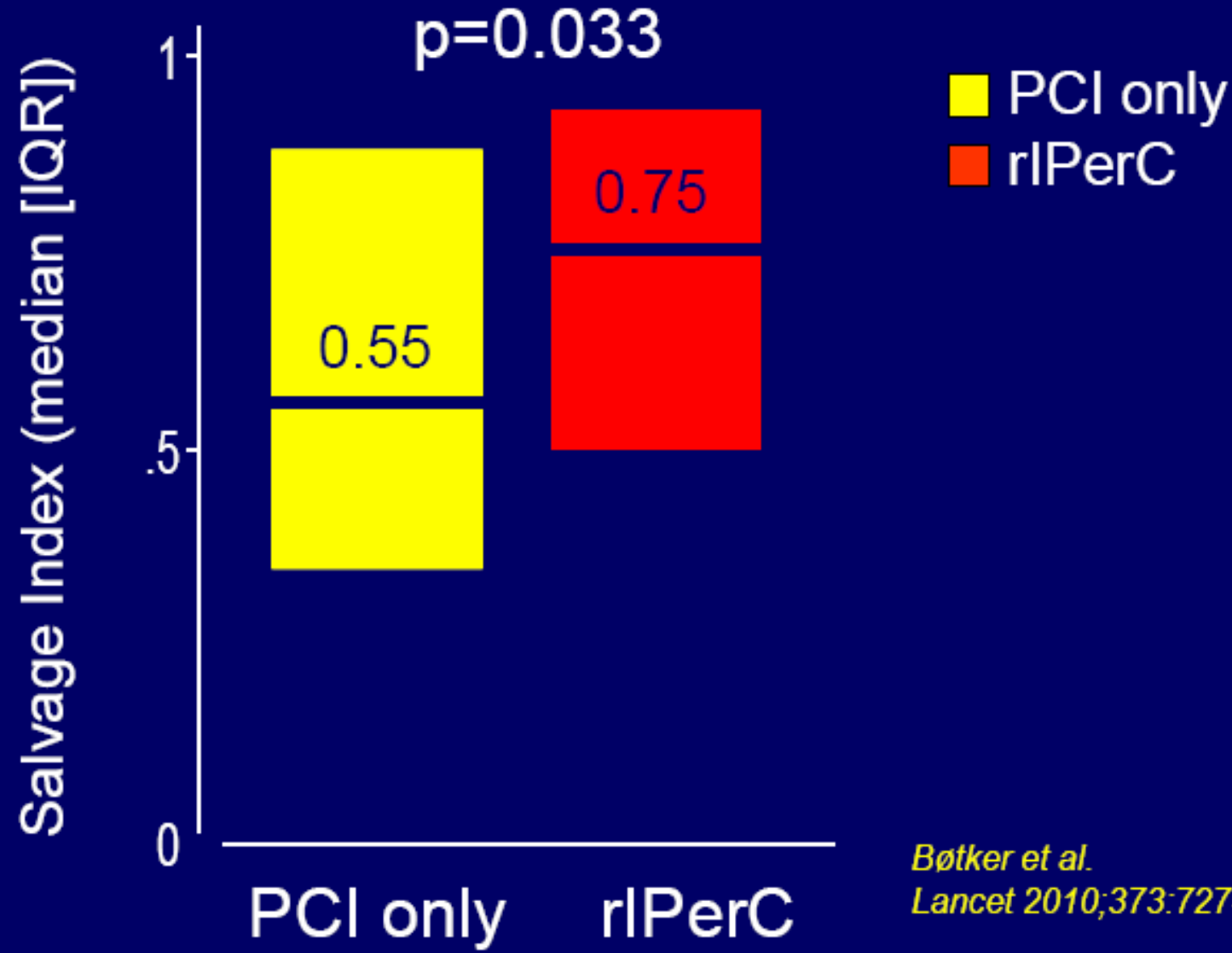
Salvage index = (AAR-FIS)/AAR





One month scan:
Final infarct size
(FIS)

OBJETIVO PRIMARIO: INDICE DE MIOCARDIO SALVADO



Bøtker et al.
Lancet 2010;373:727-34

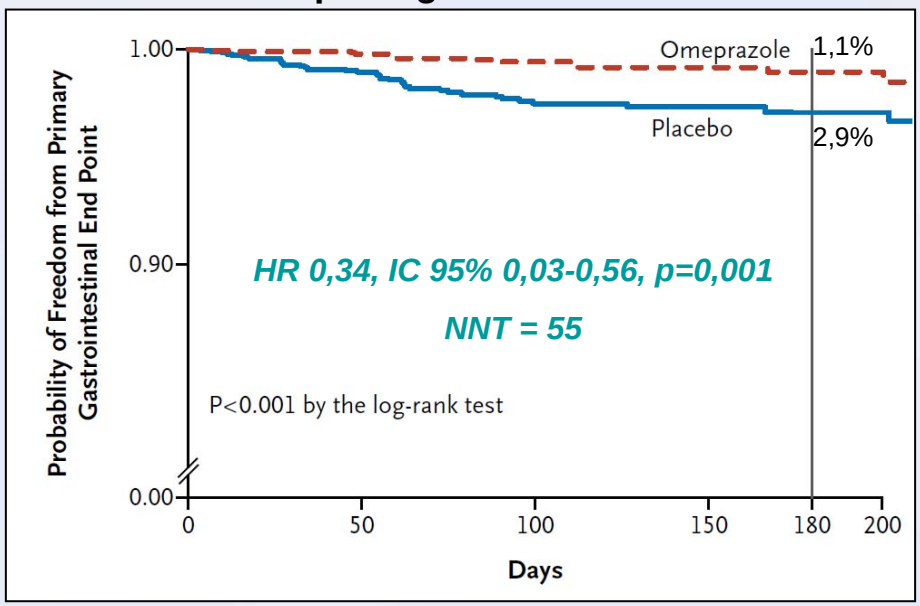
Precondicionamiento Remoto en IAM

- El precondicionamiento isquémico remoto es factible
- Las evidencia acumuladas indican que el condicionamiento isquémico remoto reduce el daño letal de la reperfusión
- Es necesario conocer y entender los mecanismos que intervienen en la fisiopatología
- El uso generalizado de esta estrategia de tratamiento requiere mas evidencias a partir de ensayos clínicos a mayor escala que demuestren beneficio clínico

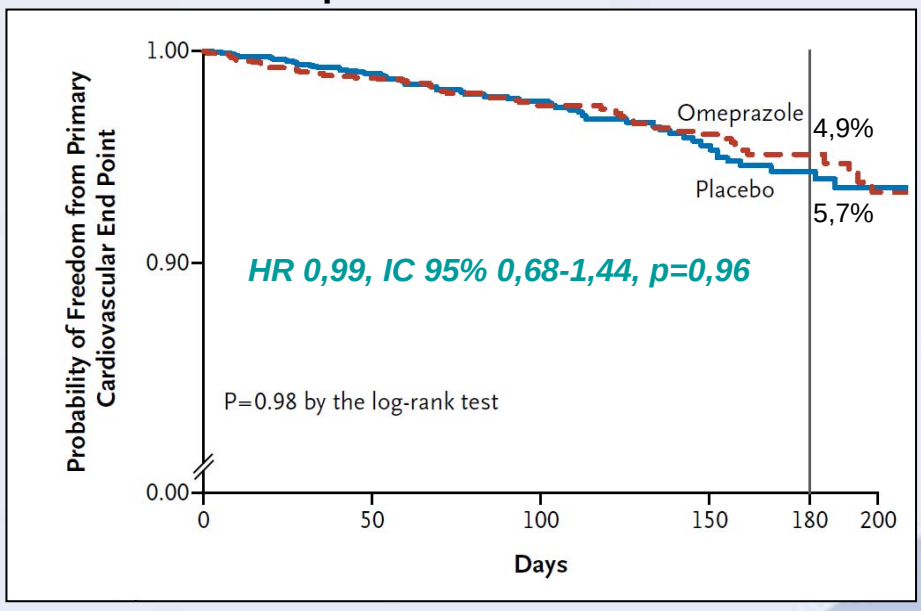
COGENT

- Suspendido prematuramente por quiebra del espónsor
- 3761 pacientes con indicación de doble antiagregación ≥ 12 meses (SCA o stent).
- Clopidogrel (75 mg/d) + omeprazol (20 mg/d) vs clopidogrel solo.
- Endpoints primarios:
    - Gastrointestinal: sangrado GI, úlcera gastroduodenal, dolor persistente de origen G-I.
    - Cardiovascular: muerte cardiovascular, IAM, revascularización o ACV isquémico.

Endpoint gastrointestinal



Endpoint cardiovascular



Transcatheter Cardiovascular Therapeutics (TCT) meeting 2009
Bhatt DL et al. N Engl J Med 2010

Lo más importante de la cardiología en 2010

- Hipertensión Arterial
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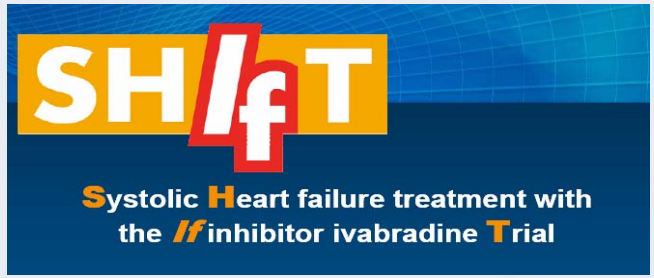
- Intervencionismo Percutáneo

Nuevas evidencias con Ivabradina en pacientes con IC

SHIFT Study

Criterios de inclusión

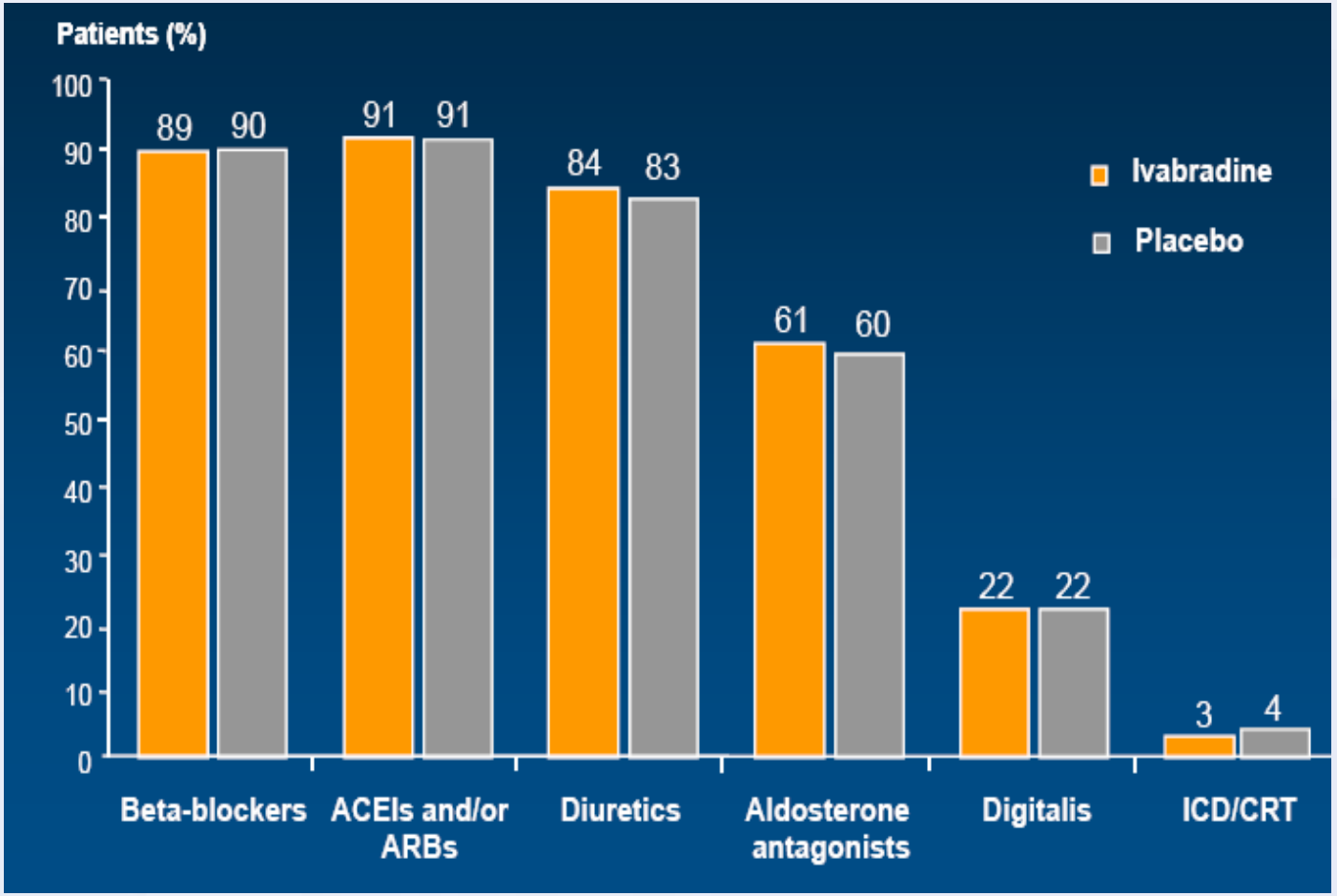


- ✓ ≥18 years
- ✓ Class II to IV NYHA heart failure
- ✓ Ischaemic/non-ischaemic aetiology
- ✓ LV systolic dysfunction (EF ≤ 35%)
- ✓ Heart rate ≥ 70 bpm
- ✓ Sinus rhythm
- ✓ Documented hospital admission for worsening heart failure ≤ 12 months

Swedberg K, et al. Eur J Heart Fail. 2010;12:75-81.

SHIFT Study

Tratamiento basal de la IC

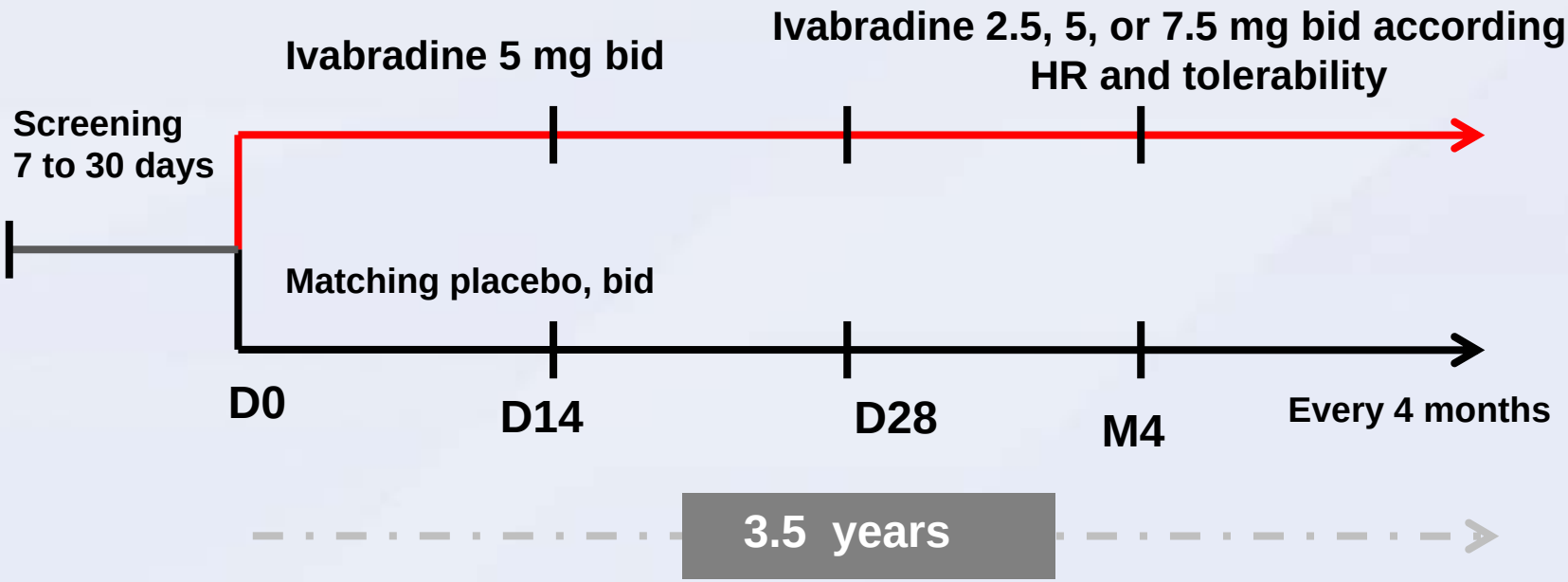


Swedberg K, et al. Lancet 2010; 376: 875–85

Diseño del estudio

PRIMARY COMPOSITE ENDPOINT:

- Cardiovascular death
- Hospitalization for worsening heart failure

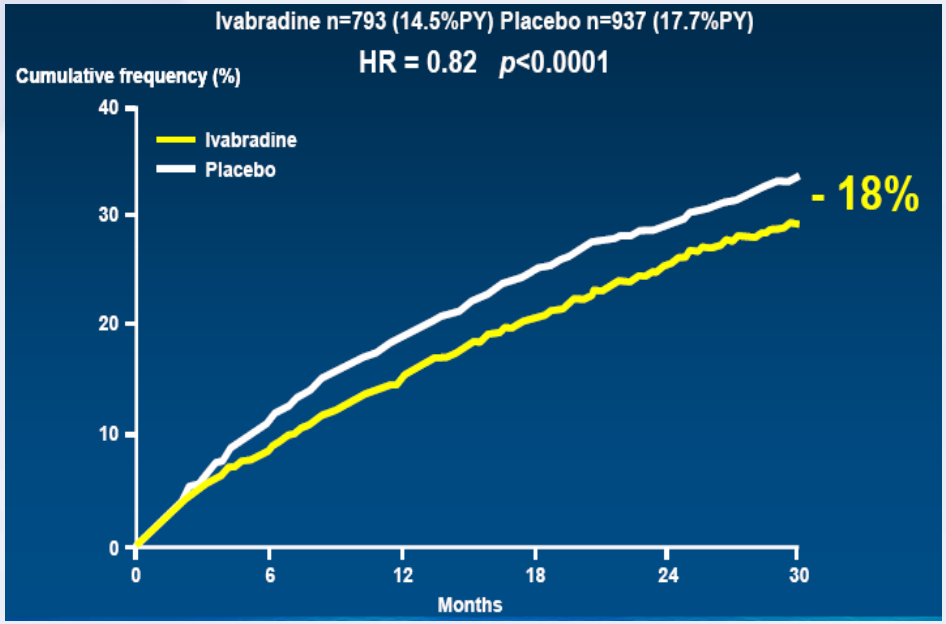


Swedberg K, et al. Eur J Heart Fail. 2010;12:75-81

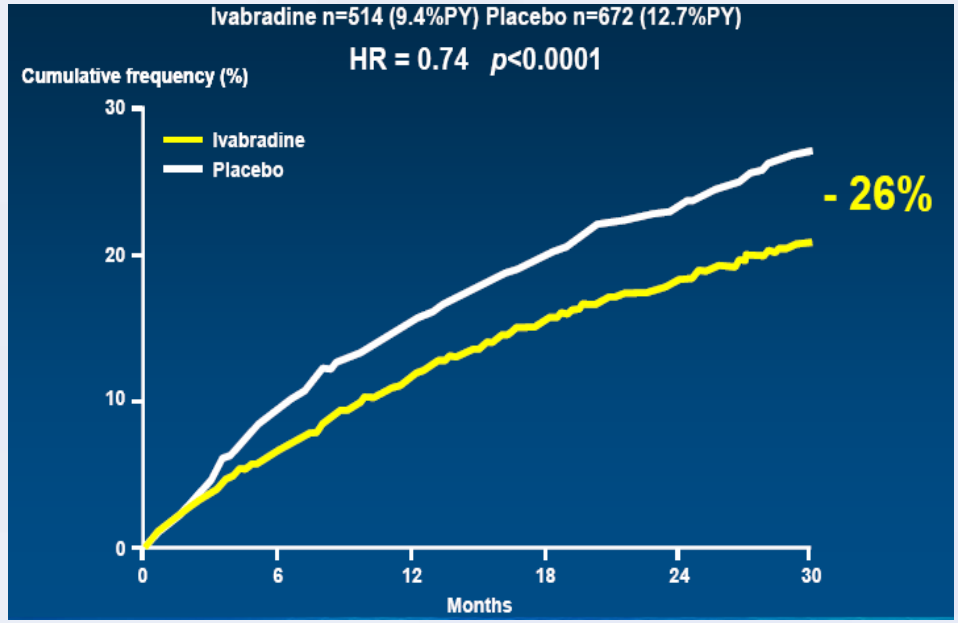
SHIFT Study

Resultados

Primary composite endpoint



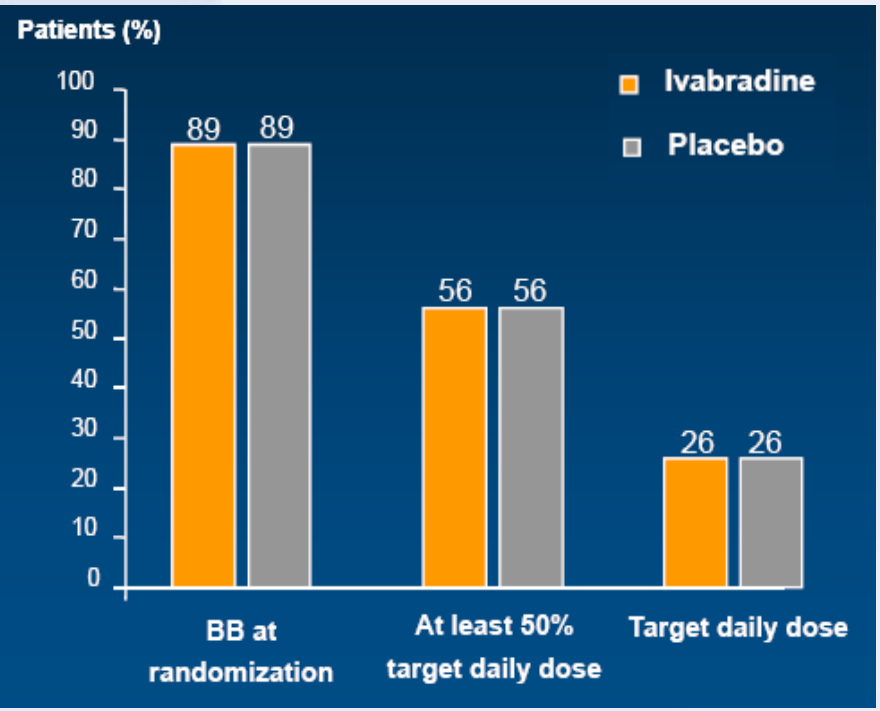
Hospitalization for heart failure



Endpoints	Hazard ratio	95% CI	*p value*
CV death	0.91	[0.80;1.03]	*p=0.128*
All-cause death	0.90	[0.80;1.02]	*p=0.092*
Death from HF	0.74	[0.58;0.94]	*p=0.014*
Hospitalization for any cause	0.89	[0.82;0.96]	*p=0.003*
Hospitalization for CV reason	0.85	[0.78;0.92]	*p=0.0002*

Swedberg K, et al. Lancet 2010; 376: 875–85

SHIFT Study Tratamiento betabloqueante (% y dos



TARGET DOSE OF BETABLOCKERS IN HEART FAILURE TRIALS AND REGISTRIES

HF trials	% BB	HF registries	% BB
CIBIS	38	COHERE(USA,2004)	44
CIBIS II	43	VA NATIONAL (USA, 2009)	25
MERIT HF	64	EURO H. SURVEY (2005)	10
COPERNICUS	65	IMPACT RECO (FR,2009)	23
SENIORS	67	IMPROVE HF (USA,2010)	17
		ESC-HF Pilot (Europe,2010)	26

Swedberg K, et al. Lancet 2010; 376: 875–85

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Eplerenone in Patients with Systolic Heart Failure and Mild Symptoms

Faiez Zannad, M.D., Ph.D., John J.V. McMurray, M.D., Henry Krum, M.B., Ph.D., Dirk J. van Veldhuisen, M.D., Ph.D., Karl Swedberg, M.D., Ph.D, Harry Shi, M.S., John Vincent, M.B., Ph.D., Stuart J. Pocock, Ph.D., and Bertram Pitt, M.D., for the EMPHASIS-HF Study Group*

POBLACIÓN DEL ESTUDIO EMPHASIS:

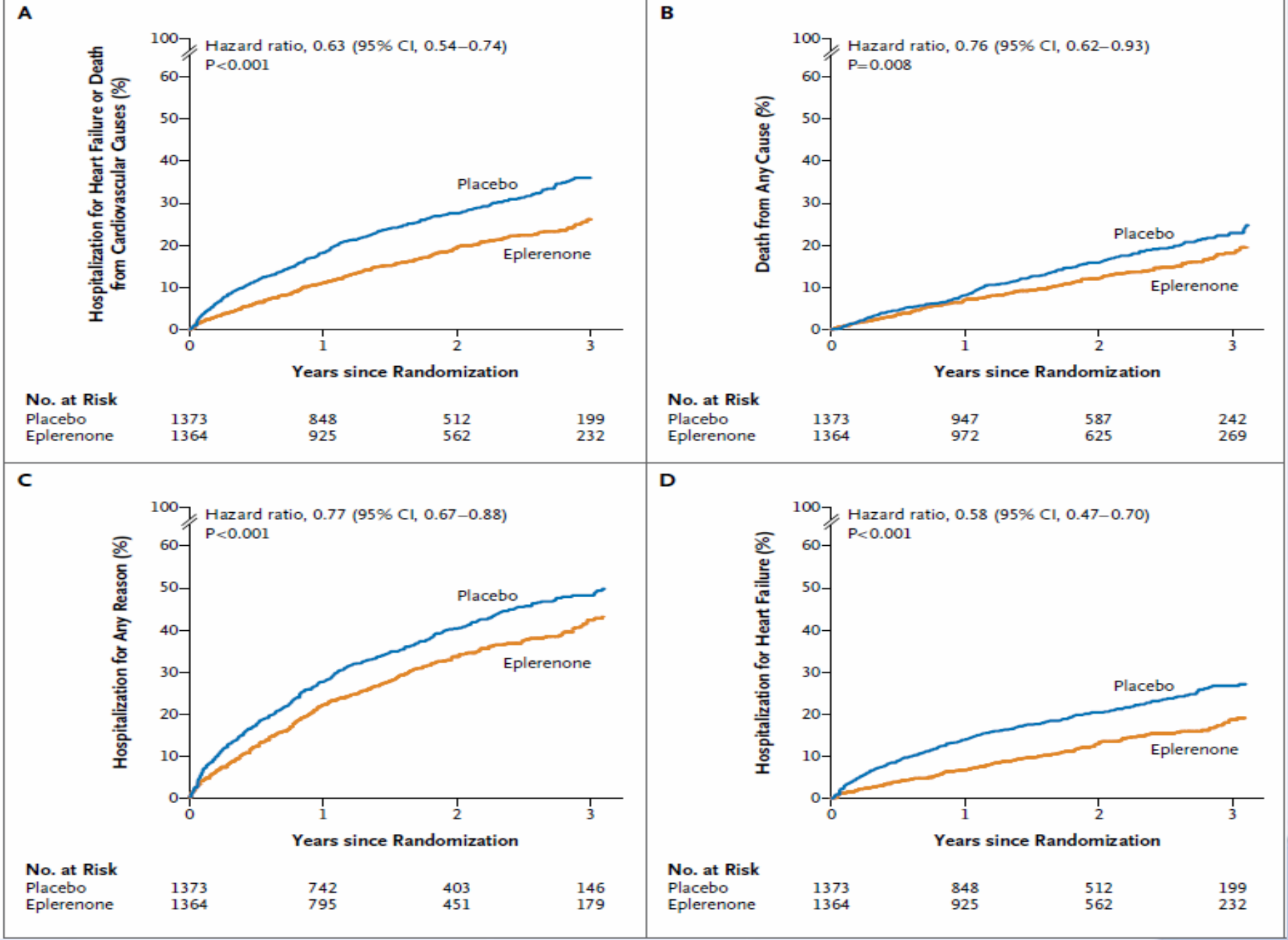
-Edad ≥55 años

-NYHA II

-FEVI no superior a 30% (si 30-35%, QRS >130 ms)

- Tratamiento a dosis recomendadas o toleradas máximas: IECA, ARA II (o ambos), BBLOQ

AHA 2010



N Engl J Med 2010.

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RACE II

RAte Control Efficacy in Permanent Atrial Fibrillation: comparison between Lenient versus Strict Rate Control II (RACE II)

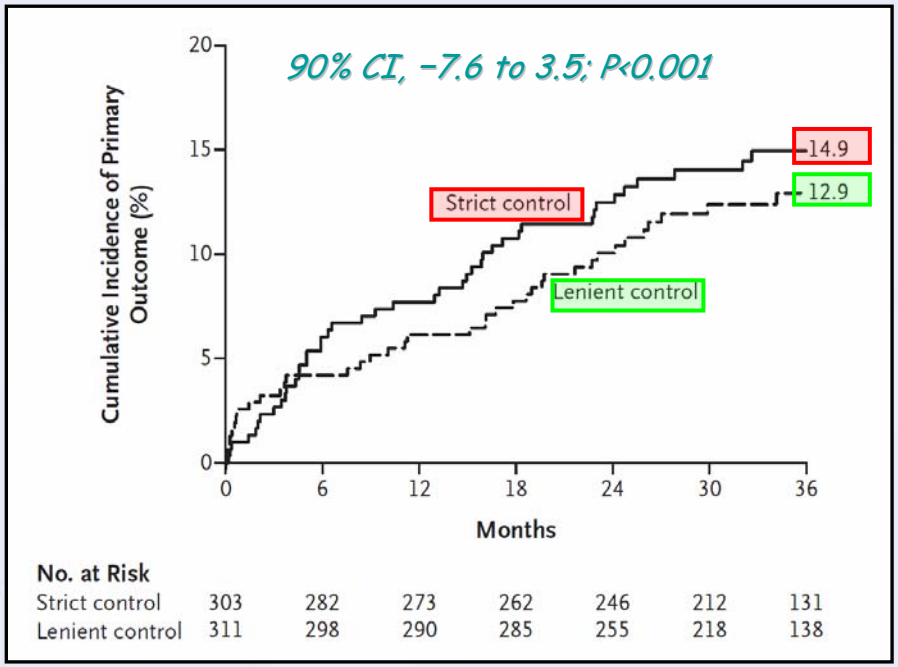

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 APRIL 15, 2010 VOL. 362 NO. 15

Lenient versus Strict Rate Control in Patients with Atrial Fibrillation

Isabelle C. Van Gelder, M.D., Hessel F. Groenveld, M.D., Harry J.G.M. Crijns, M.D., Ype S. Tuininga, M.D., Jan G.P. Tijssen, Ph.D., A. Marco Alings, M.D., Hans L. Hillege, M.D., Johanna A. Bergsma-Kadijk, M.Sc., Jan H. Cornel, M.D., Otto Kamp, M.D., Raymond Tukkie, M.D., Hans A. Bosker, M.D., Dirk J. Van Veldhuisen, M.D., and Maarten P. Van den Berg, M.D., for the RACE II Investigators*

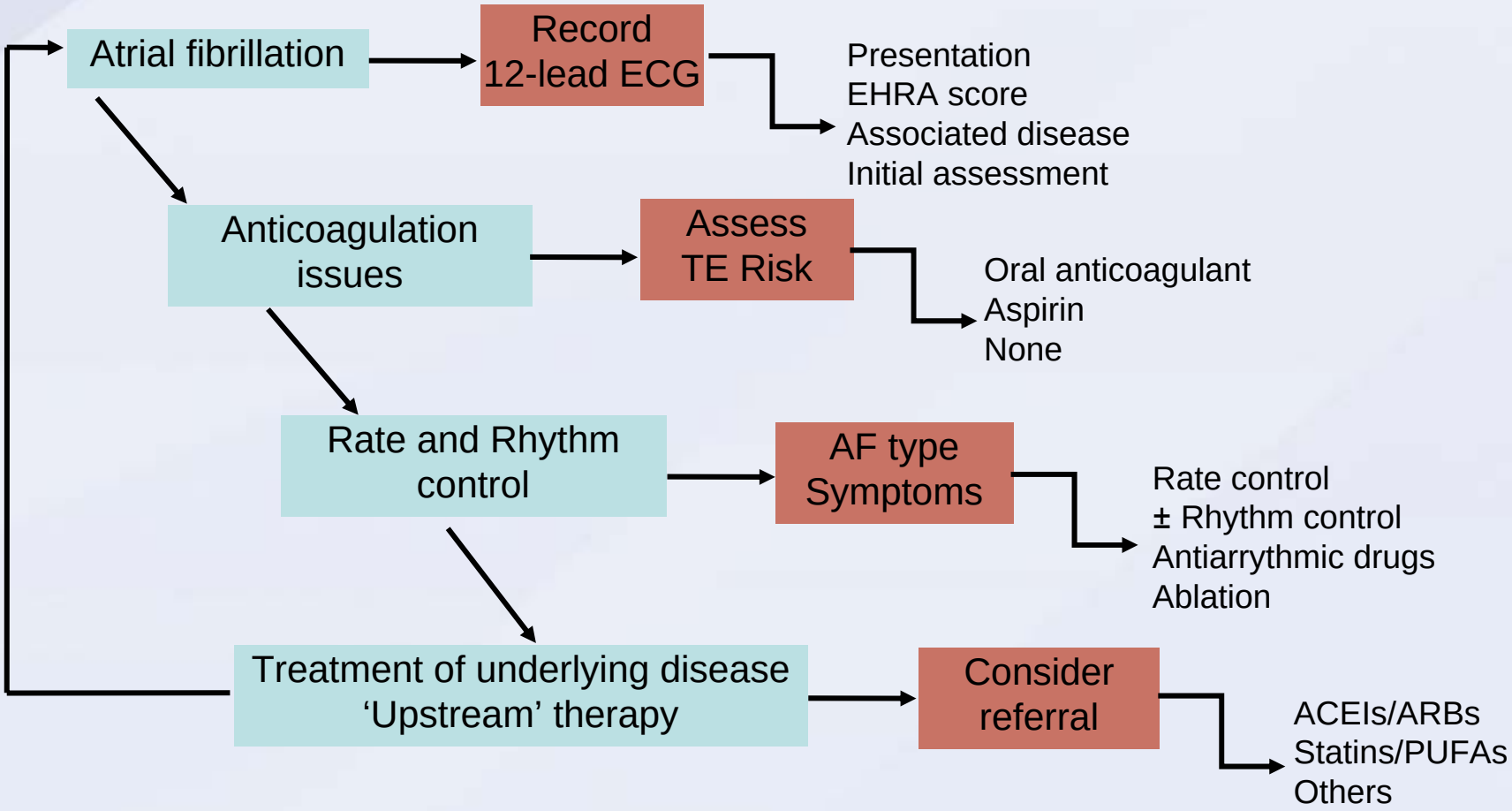
614 p FA permanente
Randomizado (1:1): -Control estricto FC (FC basal < 80, FC ejercicio < 110)
-Control laxo FC (FC basal < 110)
Seguimiento 2-3 años



Outcome	Lenient Rate Control (N=311)	Strict Rate Control (N=303)	Hazard Ratio (90% CI)
	no. of patients (%)		
Composite primary outcome	38 (12.9)	43 (14.9)	0.84 (0.58–1.21)
Individual components			
Death from cardiovascular cause	9 (2.9)	11 (3.9)	0.79 (0.38–1.65)
From cardiac arrhythmia	3 (1.0)	4 (1.4)	
From cardiac cause other than arrhythmia	1 (0.3)	2 (0.8)	
From noncardiac vascular cause	5 (1.7)	5 (1.9)	
Heart failure	11 (3.8)	11 (4.1)	0.97 (0.48–1.96)
Stroke	4 (1.6)	11 (3.9)	0.35 (0.13–0.92)
Ischemic	3 (1.3)	8 (2.9)	
Hemorrhagic	1 (0.3)	4 (1.5)	
Systemic embolism	1 (0.3)	0	
Bleeding	15 (5.3)	13 (4.5)	1.12 (0.60–2.08)
Intracranial	0	3 (1.0)	
Extracranial	15 (5.3)	10 (3.5)	
Syncope	3 (1.0)	3 (1.0)	
Life-threatening adverse effect of rate-control drugs	3 (1.1)	2 (0.7)	
Sustained ventricular tachycardia or ventricular fibrillation	0	1 (0.3)	
Cardioverter–defibrillator implantation	0	1 (0.3)	
Pacemaker implantation	2 (0.8)	4 (1.4)	

Van Gelder et al. *New Engl J Med* 2010
(ClinicalTrials.gov number, NCT00392613)

Fibrilación auricular. Guías ESC 2010



www.escardio.org/guidelines

Fibrilación auricular. ESC 2010

Highlights

1. Presentación clínica y diagnóstico
2. Refinamiento riesgo tromboembolismo y hemorragia
3. Nuevas recomendaciones de tratamiento
4. Ablación como método de tratamiento

CHA_2DS_2-VASc	Score
CHF	1
HTA	1
Age ≥ 75	2
Diabetes	1
Stroke/AIT/TE	2
Enfermedad Vascular	1
Age 65-75	1
Sexo (i.e. femenino) < 75	1

CHA_2DS_2-VASc		Tasa ACV (% año)
0	Nada/AAS	0
1	ACO/AAS	1.3
2	ACO	2.2
3		3.2
4		4.0
5		6.7
6		9.8
7		9.6
8		6.7
9		15.2

H	Hypertension	1
A	Abnormal renal/liver	1 ó 2
S	Stroke	1
B	Bleeding	1
L	Labile INR	1
E	Elderly (>75)	1
D	Drugs/Alcohol	1 ó 2

HAS-BLED ≤ 2: Dabigatran 150 mgs bid
HAS-BLED > 2: Dabigatran 110 mgs bid

Clase I nivel evidencia A

Camm et al. *Eur Heart J 2010,* doi:10.1093/eurheartj/ehq278

Phase III trials comparing new anticoagulants in AF

1. Versus Warfarin

   Direct Thrombin inhibition:

   - Ximelagatran (Sportif III & V) - 2003, 2005
   - Dabigatran (RELY) 2009

   Direct factor Xa inhibition:

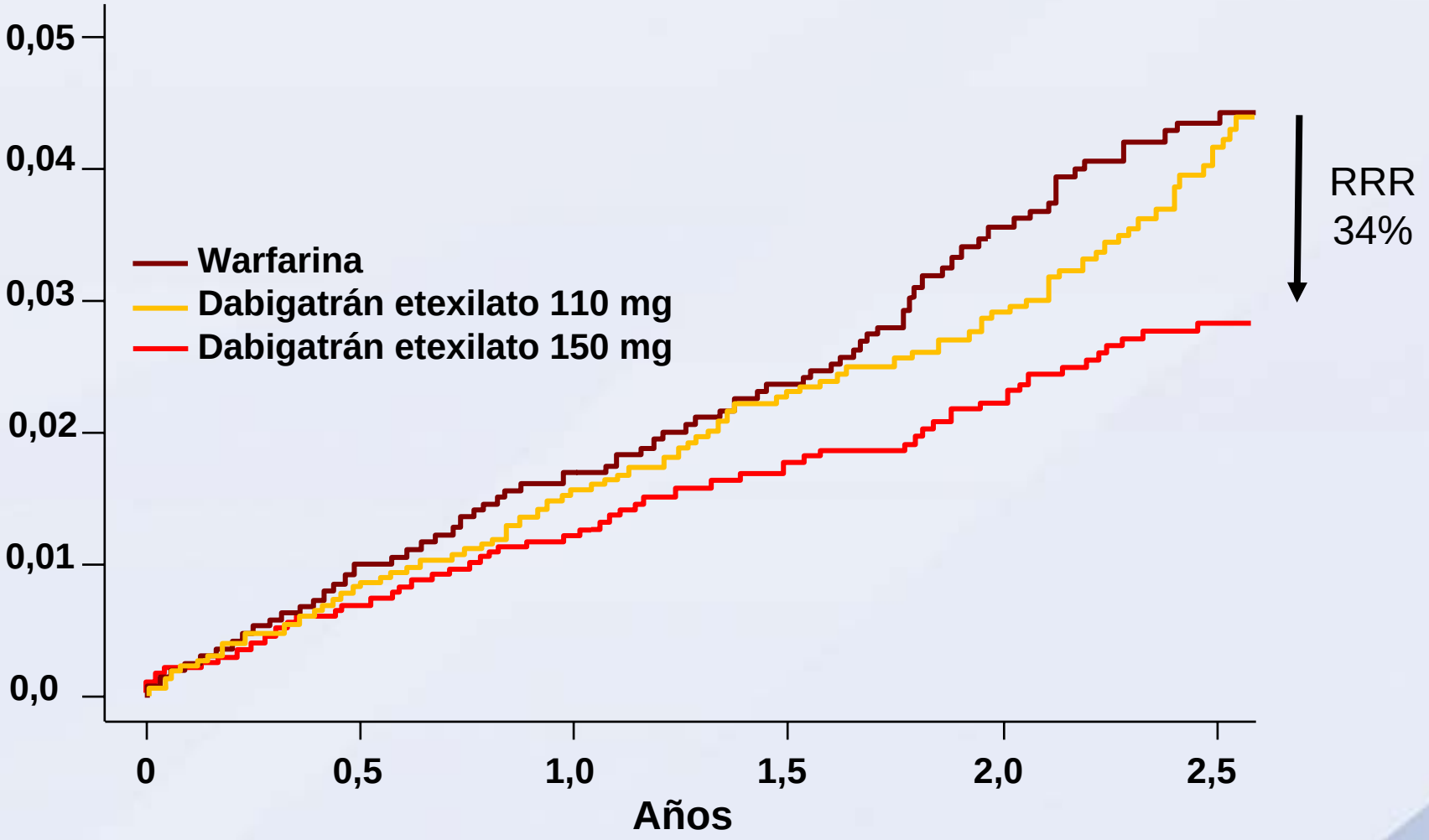
   - Ribaroxaban (ROCKET) – Nov 2010
   - Apixaban (ARISTOTELE) – Aug 2011
   - Edoxaban (ENGAGE AF – TIMI48) – 2012?
   - Betrixaban (start phase III2011?) – 2014?

2. Versus Aspirin:

   Apixaban (AVERROES) Aug 2010

E. RE-LY.

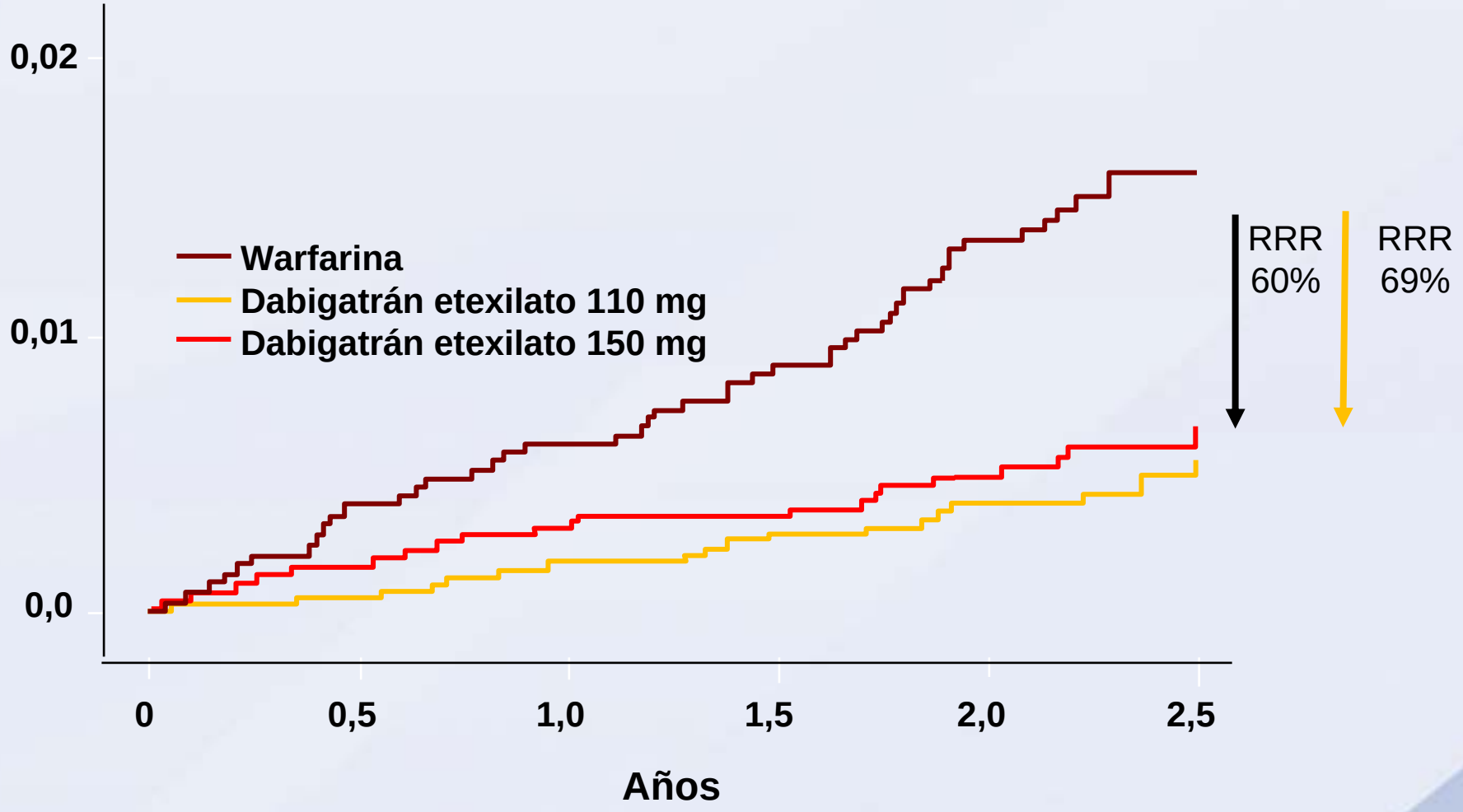
FA. Tiempo hasta el primer ictus/ES



Connolly SJ., et al. NEJM publicado en línea el 30 de agosto de 2009.
DOI 10.1056/NEJMoa0905561

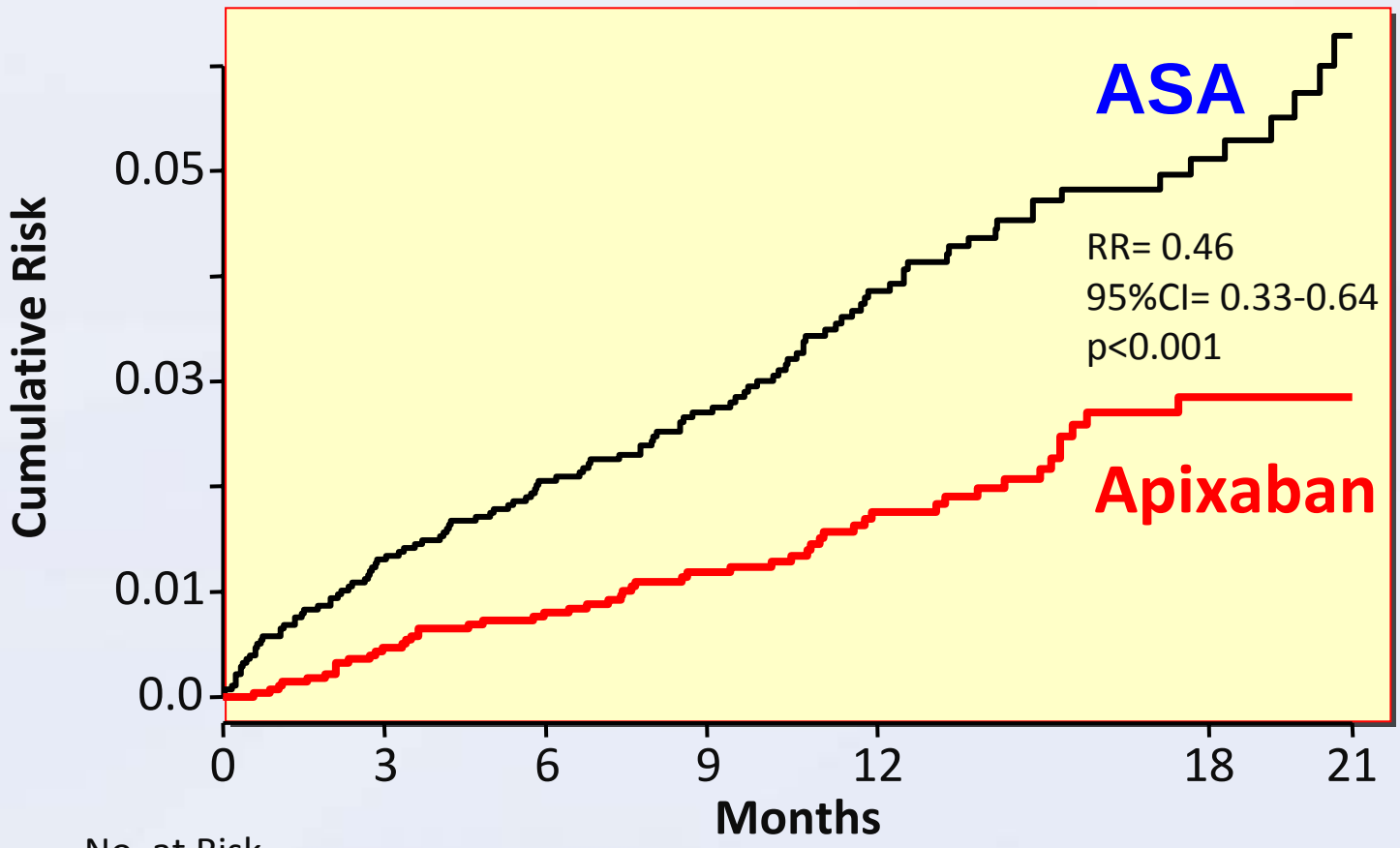
E. RE-LY.

Tiempo hasta la primera hemorragia intracraneal



Connolly SJ., et al. NEJM. DOI 10.1056/NEJMoa0905561

AVERROES
Stroke or Systemic Embolic Event

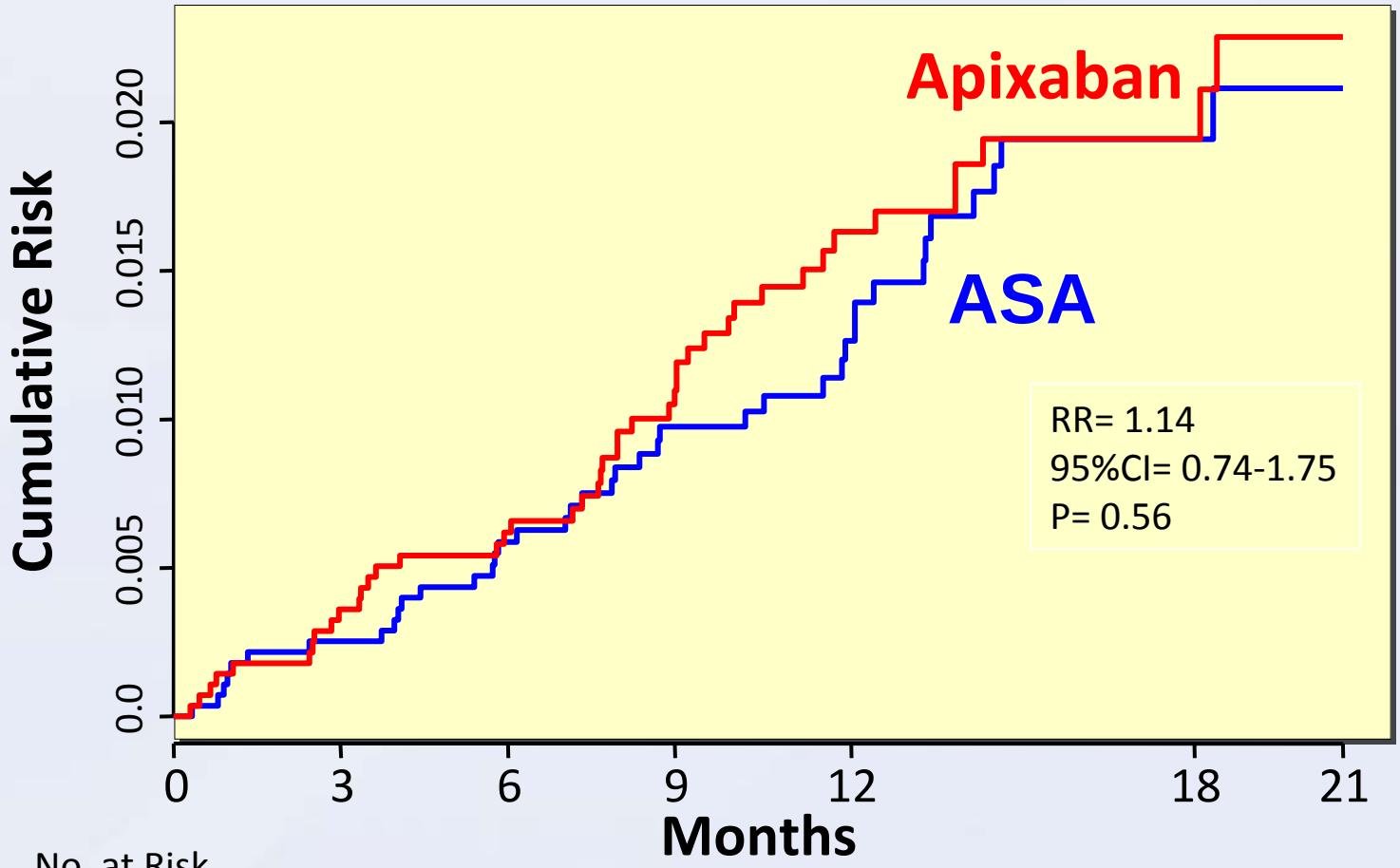


No. at Risk

ASA	2791	2720	2541	2124	1541	626	329
Apix	2809	2761	2567	2127	1523	617	353

ESC Hotline 2010

AVERROES
Major Bleeding

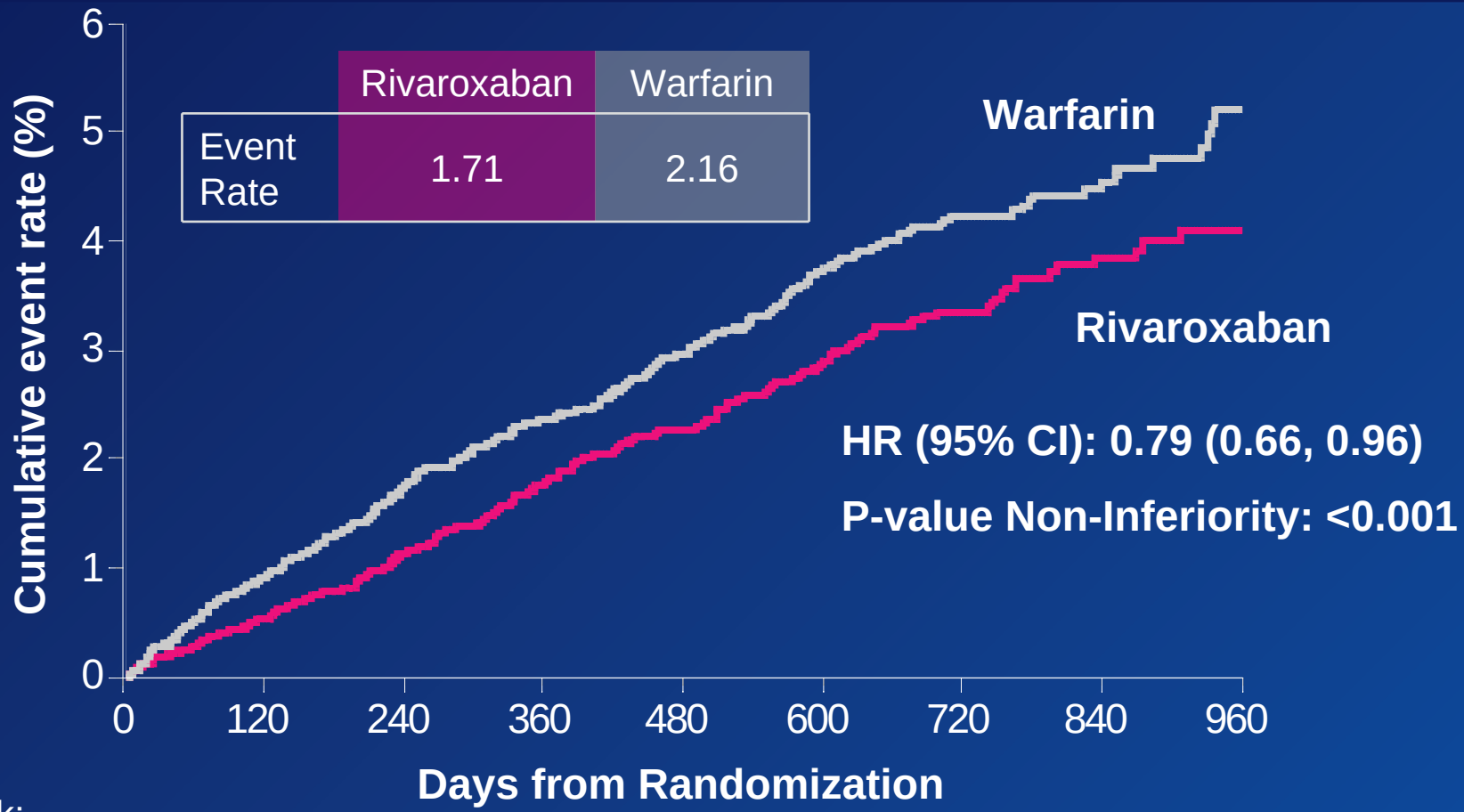


No. at Risk

ASA	2791	2744	2572	2152	1570	642	340
Apix	2809	2763	2567	2123	1521	622	357

ESC Hotline 2010

Primary Efficacy Outcome
Stroke and non-CNS Embolism



No. at risk:

Rivaroxaban	6958	6211	5786	5468	4406	3407	2472	1496	634
Warfarin	7004	6327	5911	5542	4461	3478	2539	1538	655

Event Rates are per 100 patient-years
Based on Protocol Compliant on Treatment Population

ROCKET AF

Primary Safety Outcomes

	Rivaroxaban	Warfarin		
	Event Rate or N (Rate)	Event Rate or N (Rate)	HR (95% CI)	P-value
Major	3.60	3.45	1.04 (0.90, 1.20)	0.576
≥2 g/dL Hgb drop	2.77	2.26	1.22 (1.03, 1.44)	0.019
Transfusion (> 2 units)	1.65	1.32	1.25 (1.01, 1.55)	0.044
Critical organ bleeding	0.82	1.18	0.69 (0.53, 0.91)	0.007
Bleeding causing death	0.24	0.48	0.50 (0.31, 0.79)	0.003
Intracranial Hemorrhage	55 (0.49)	84 (0.74)	0.67 (0.47, 0.94)	0.019
Intraparenchymal	37 (0.33)	56 (0.49)	0.67 (0.44, 1.02)	0.060
Intraventricular	2 (0.02)	4 (0.04)		
Subdural	14 (0.13)	27 (0.27)	0.53 (0.28, 1.00)	0.051
Subarachnoid	4 (0.04)	1 (0.01)		

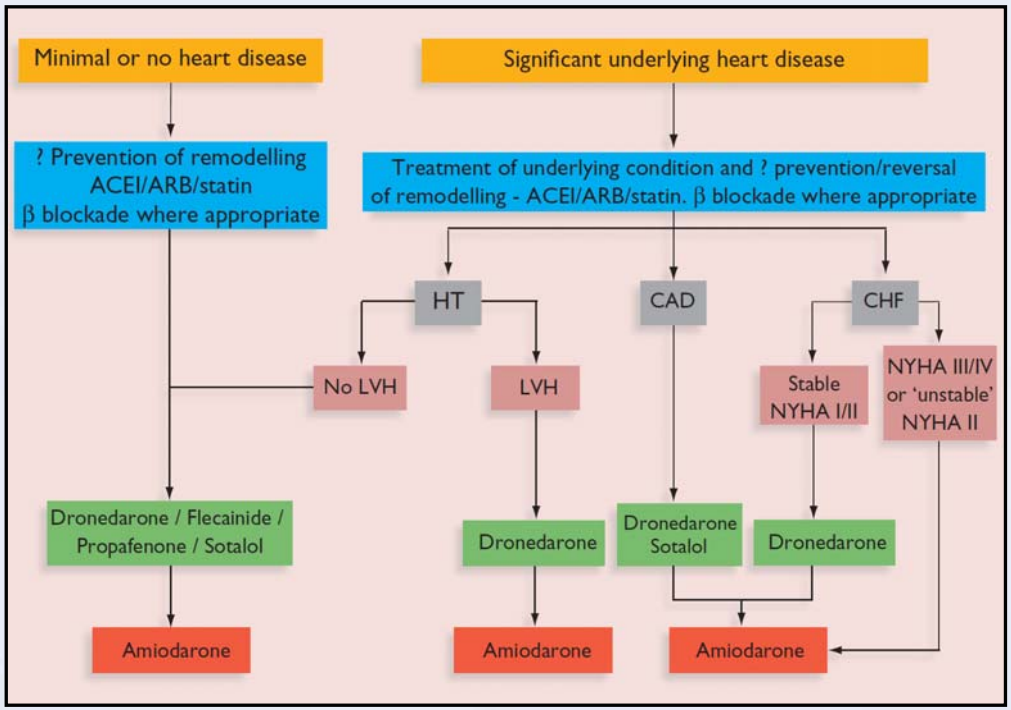
Event Rates are per 100 patient-years
Based on Safety on Treatment Population

ROCKET AF

Fibrilación auricular. ESC 2010

Highlights

1. Presentación clínica y diagnóstico
2. Refinamiento riesgo tromboembolismo y hemorragia
3. Nuevas recomendaciones de tratamiento
4. Ablación como método de tratamiento



Recommendations	Class[a]	Level[b]
The following antiarrhythmic drugs are recommended for rhythm control in patients with AF, depending on underlying heart disease:		
• amiodarone	I	A
• dronedarone	I	A
• flecainide	I	A
• propafenone	I	A
• d,l-sotalol	I	A
Amiodarone is more effective in maintaining sinus rhythm than sotalol, propafenone, flecainide (by analogy), or dronedarone (LoE A), but because of its toxicity profile should generally be used when other agents have failed or are contraindicated (LoE C).	I	A / C

Camm et al. *Eur Heart J 2010,* doi:10.1093/eurheartj/ehq278

Fibrilación auricular. ESC 2010

Highlights

1. Presentación clínica y diagnóstico
2. Refinamiento riesgo tromboembolismo y hemorragia
3. Nuevas recomendaciones de tratamiento
4. Ablación como método de tratamiento

Recommendations	Class[a]	Level[b]
Ablation of common atrial flutter is recommended as part of an AF ablation procedure if documented prior to the ablation procedure or occurring during the AF ablation.	I	B
Catheter ablation for paroxysmal AF should be considered in symptomatic patients who have previously failed a trial of antiarrhythmic medication.	IIa	A
Ablation of persistent symptomatic AF that is refractory to antiarrhythmic therapy should be considered a treatment option.	IIa	B
Catheter ablation of AF in patients with heart failure may be considered when antiarrhythmic medication, including amiodarone, fails to control symptoms.	IIb	B
Catheter ablation of AF may be considered prior to antiarrhythmic drug therapy in symptomatic patients despite adequate rate control with paroxysmal symptomatic AF and no significant underlying heart disease.	IIb	B

"(...) considering the potential of AF catheter ablation to achieve rhythm control in symptomatic patients with paroxysmal AF and minimal or noheart disease, and the relative safety of the technique when performed by experienced operators, ablation may be considered as an initial therapy in selected patients."

Camm et al. *Eur Heart J 2010,* doi:10.1093/eurheartj/ehq278

El tema del año

European Heart Journal
doi:10.1093/eurheartj/ehq278

Guidelines for the management of atrial fibrillation

The Task F … of the European S…

Developed wi… Association (EHRA)†

Endorsed by t… EACTS)

Authors/Task … ulus Kirchhof (Germany), G…), Irene Saveliev… Netherlands), Nawwar Al-A… rendergast (UK), Hein H… gelini …), Dan Atar (No… hek (T…), Johan De Sutt… h (Be…), Magnus Helda… utten, Jean-Yves Le … (The Netherl…

ESC Committee fo… Auricch… (Switzerland), Jero… rasimos… (Greece), Christian… eresa M… (UK), Bogdan A. Popescu (Romania), Zeljko Reiner (Croatia), Udo Sechtem (Germany), Per Anton Sir… (Norway), Michal T…

Document Reviewe… a), Etienne Aliot (France), Tosho Bal… taly), Harry Crijns (The Netherlands), … nix Goethals (Belgium), Dietrich… Sedat Kose (Turkey), John McM… esus Salvador (Spain), Martin J. Sc… ortugal), Janina Stepinska (P… a).

The disclosure form… g/guidelines

Recommendations	Class[a]	Level[b]
Ablation of common atrial flutter is recommended as part of an AF ablation procedure if documented prior to the ablation procedure or occurring during the AF ablation.	I	B
Catheter ablation for paroxysmal AF should be considered in symptomatic patients who have previously failed a trial of antiarrhythmic medication.	IIa	A
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The following antiarrhythmic drugs are recommended for rhythm control in patients with AF, depending on underlying heart disease:		
• amiodarone	I	A
• dronedarone	I	A
• flecainide	I	A

(…) where oral anticoagulation is appropriate therapy, dabigatran may be considered, as an alternative to adjusted dose VKA therapy

* Corresponding auth… 3416, Email: jcarm@xgu.ac.uk

† Other ESC entities having participated in the development of this document:
Associations: European Association of Echocardiography (EAE), European Association for Cardiovascular Prevention & Rehabilitation (EACPR), Heart Failure Association (HFA).
Working Groups: Cardiovascular Surgery, Developmental Anatomy and Pathology, Cardiovascular Pharmacology and Drug Therapy, Thrombosis, Acute Cardiac Care, Valvular Heart Disease.
Councils: Cardiovascular Imaging, Cardiology Practice, Cardiovascular Primary Care.

European Heart Journal
doi:10.1093/eurheartj/ehq337

2010 Focused Update of ESC guidelines on device therapy in heart failure

An update of the 2008 ESC guidelines for the diagnosis and treatment of acute and chronic heart failure and the 2007 ESC guidelines for cardiac and resynchronization therapy

Developed with the special contribution of the Heart Failure Association and the European Heart Rhythm Association

Authors/Task Force Members, Kenneth Dickstein (Chairperson) (Norway)*, Panos E. Vardas (Chairperson) (Greece)*, Angelo Auricchio (Switzerland), …

Recommendation	Patient population	Class[a]	Level[b]
CRT preferentially by CRT-D is recommended to reduce morbidity or to prevent disease progression[d]	NYHA function class II LVEF ≤35%, QRS ≥150 ms, SR Optimal medical therapy	I	A

The disclosure forms of the authors and reviewers are available on the ESC website www.escardio.org/guidelines

Keywords: Guidelines • Heart failure • Devices • Cardiac resynchronization therapy • Biventricular pacing • Implantable cardioverter defibrillator • Left ventricular assist device • CRT • CRT-P • CRT-D • ICD • LVAD

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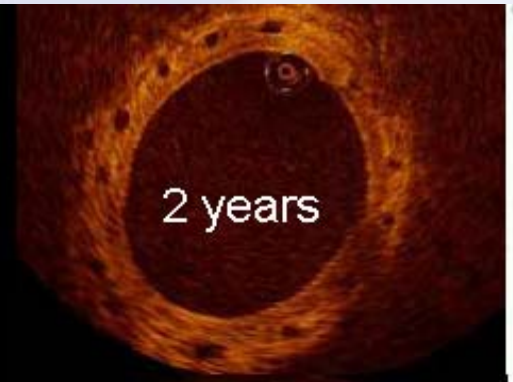
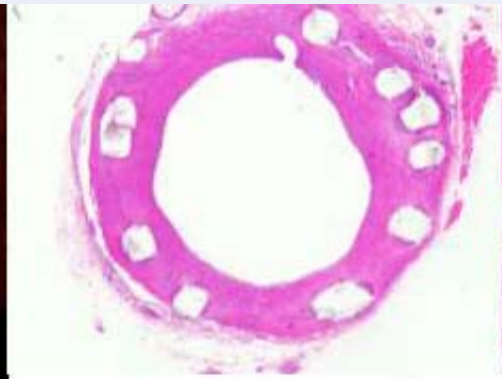
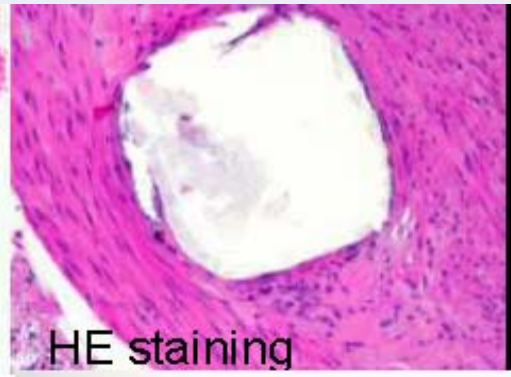
Lo más importante de la cardiología en 2010

- Hipertensión Arterial
- Cardiopatía Isquémica
- Insuficiencia Cardiaca
- Arritmias
- Intervencionismo Percutáneo

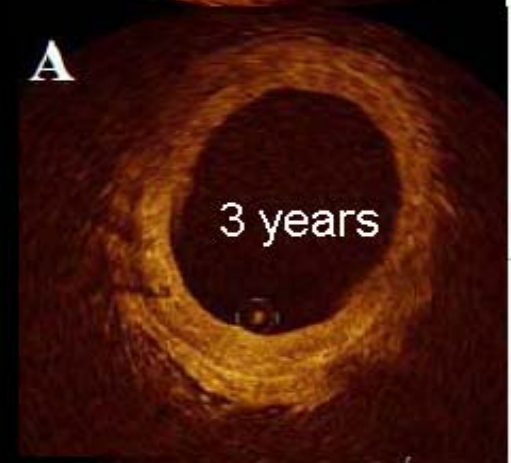
Stent Bioabsorbible

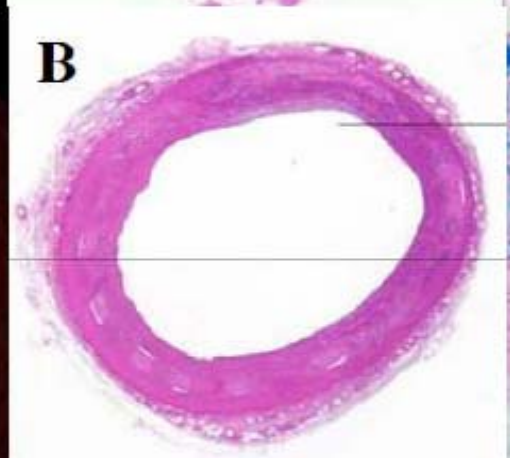


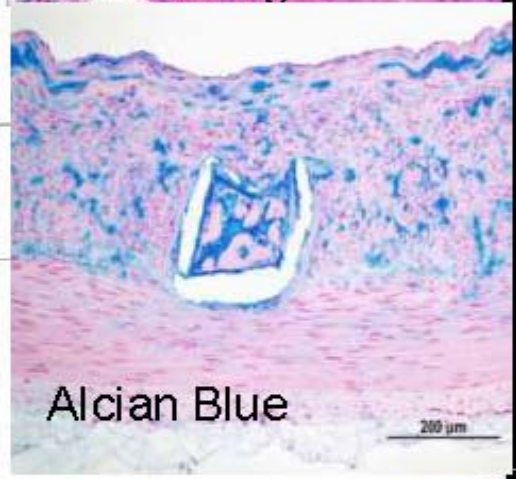




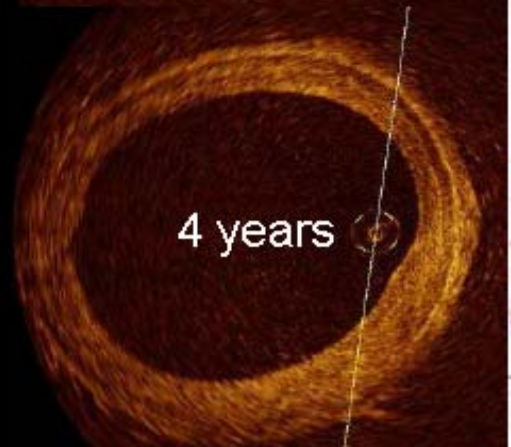
By chromatography, polymeric struts were no longer detectable

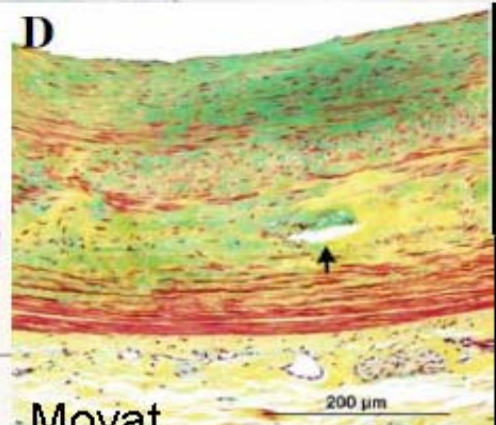






Strut voids were filled with young proteoglycan and coalesced with vessel wall.





collagen = yellow
proteoglycans/muco polysaccharides = blue/green
SMCs = red

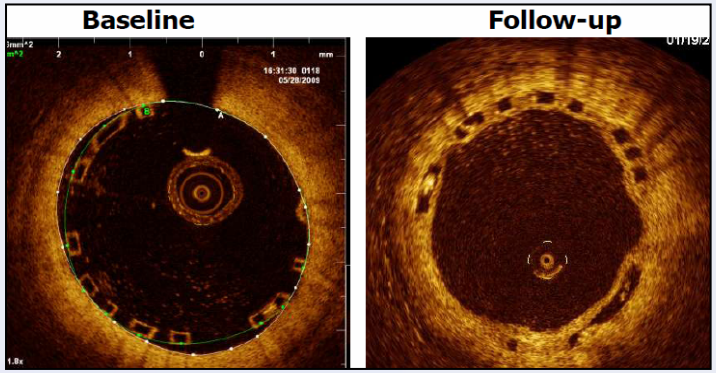
density of smooth muscle cells at the presumed site of polymeric struts

PCR 2010

ABSORB “Cohort B” Trial

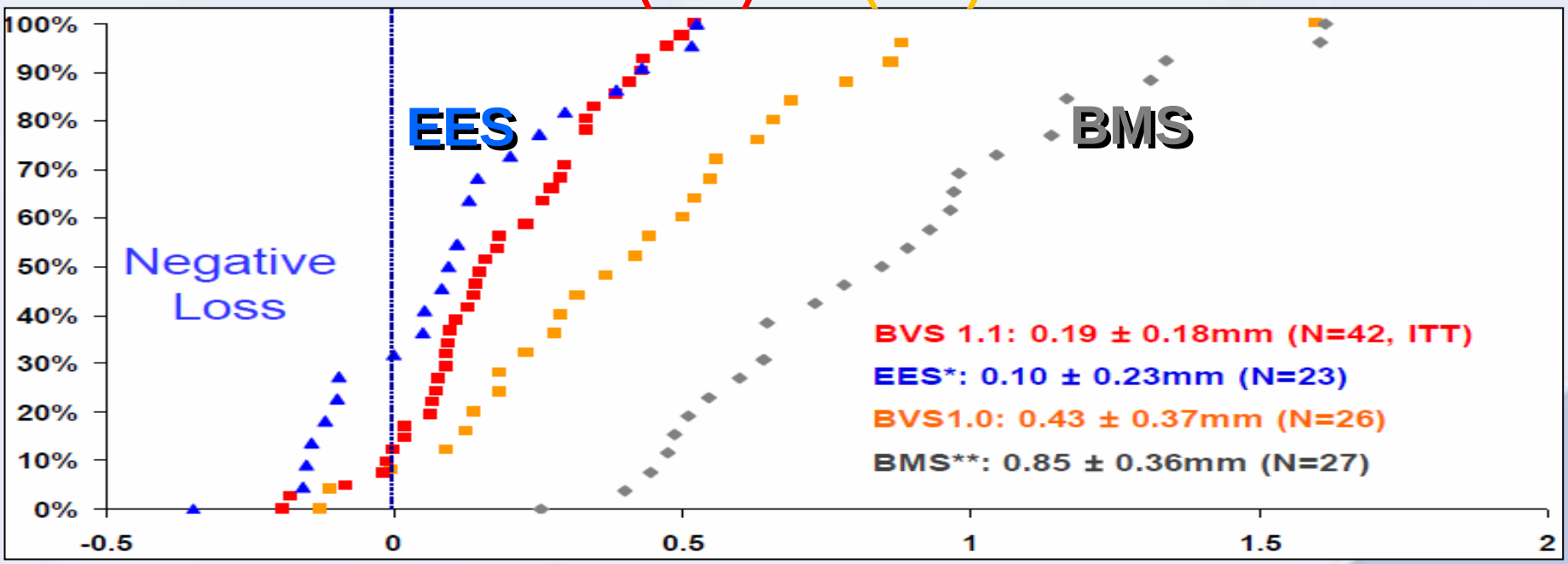
Bioresorbable Everolimus-Eluting Vascular Scaffold (BVS)

45 Patients



Late Loss (mm)

ABSORB B (0.19) **ABSORB A (0.43)**



Novedades en Intervencionismo Percutáneo

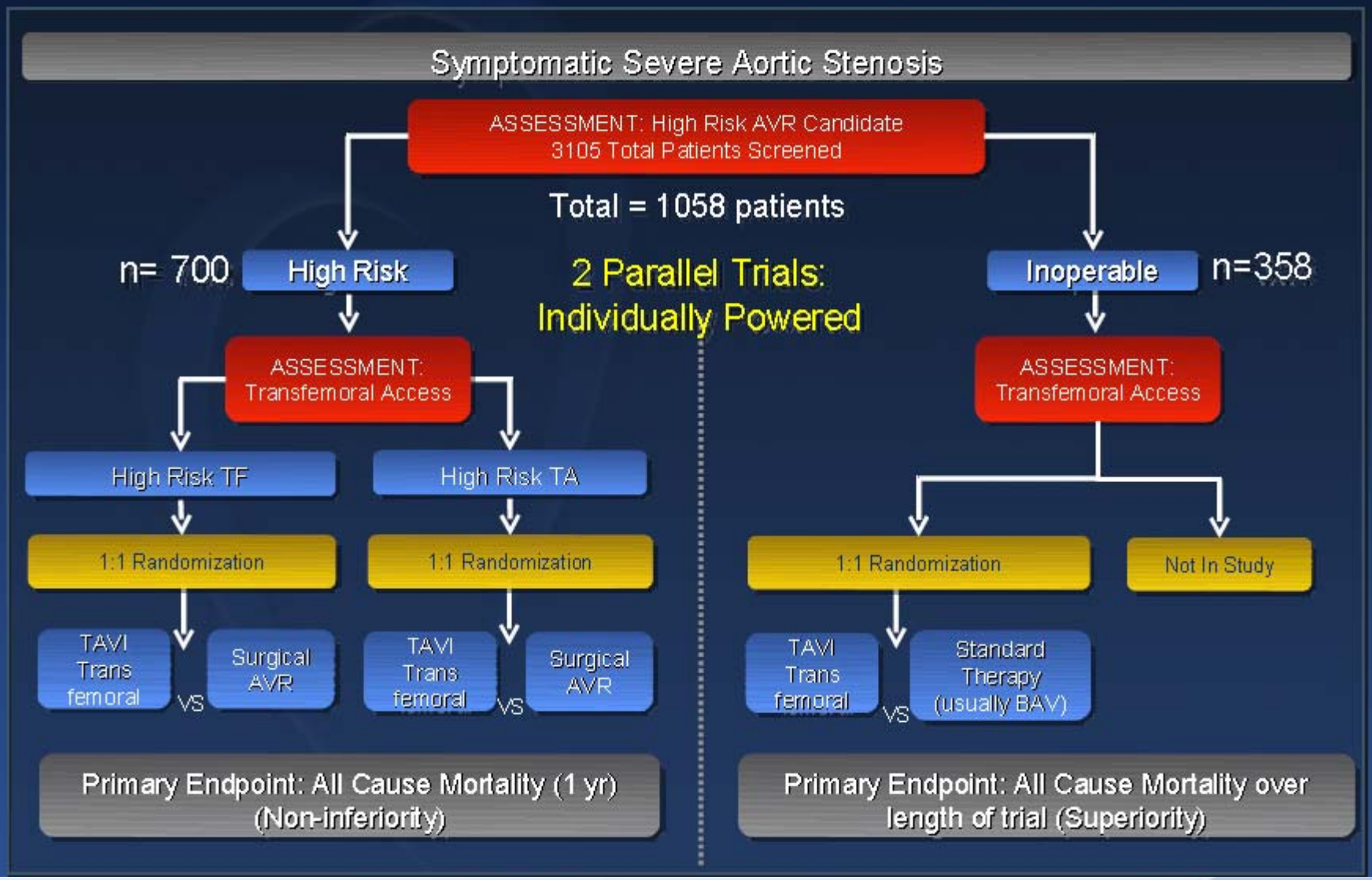
The NEW ENGLAND JOURNAL of MEDICINE

Transcatheter Aortic-Valve Implantation for Aortic Stenosis in Patients Who Cannot Undergo Surgery

Martin B. Leon, M.D., Craig R. Smith, M.D., Michael Mack, M.D., D. Craig Miller, M.D., Jeffrey W. Moses, M.D., Lars G. Svensson, M.D., Ph.D., E. Murat Tuzcu, M.D., John G. Webb, M.D., Gregory P. Fontana, M.D., Raj R. Makkar, M.D., David L. Brown, M.D., Peter C. Block, M.D., Robert A. Guyton, M.D., Augusto D. Pichard, M.D., Joseph E. Bavaria, M.D., Howard C. Herrmann, M.D., Pamela C. Douglas, M.D., John L. Petersen, M.D., Jodi J. Akin, M.S., William N. Anderson, Ph.D., Duolao Wang, Ph.D., and Stuart Pocock, Ph.D., for the PARTNER Trial Investigators*

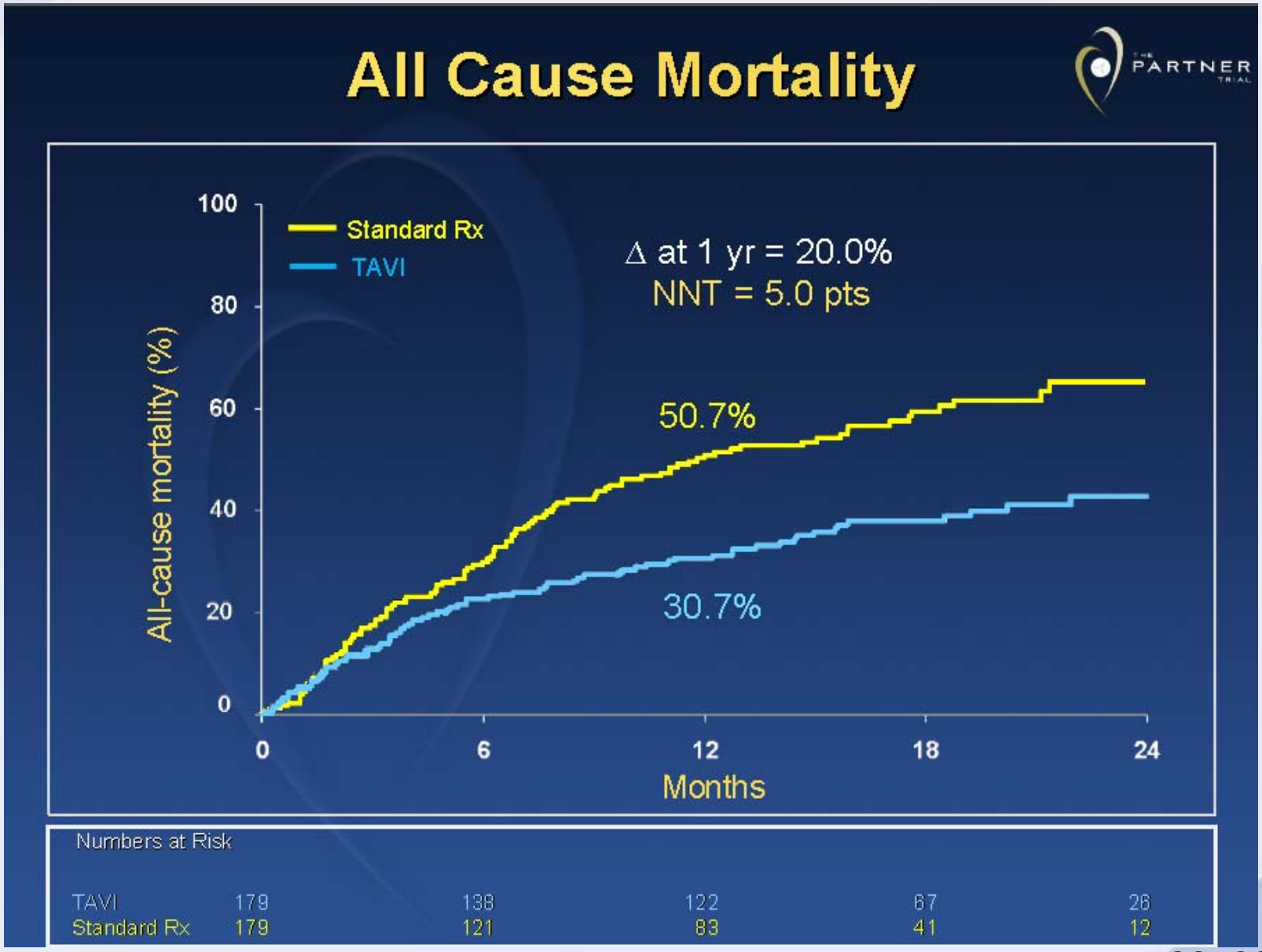
NEJM sept 22, 2010

PARTNER Study Design



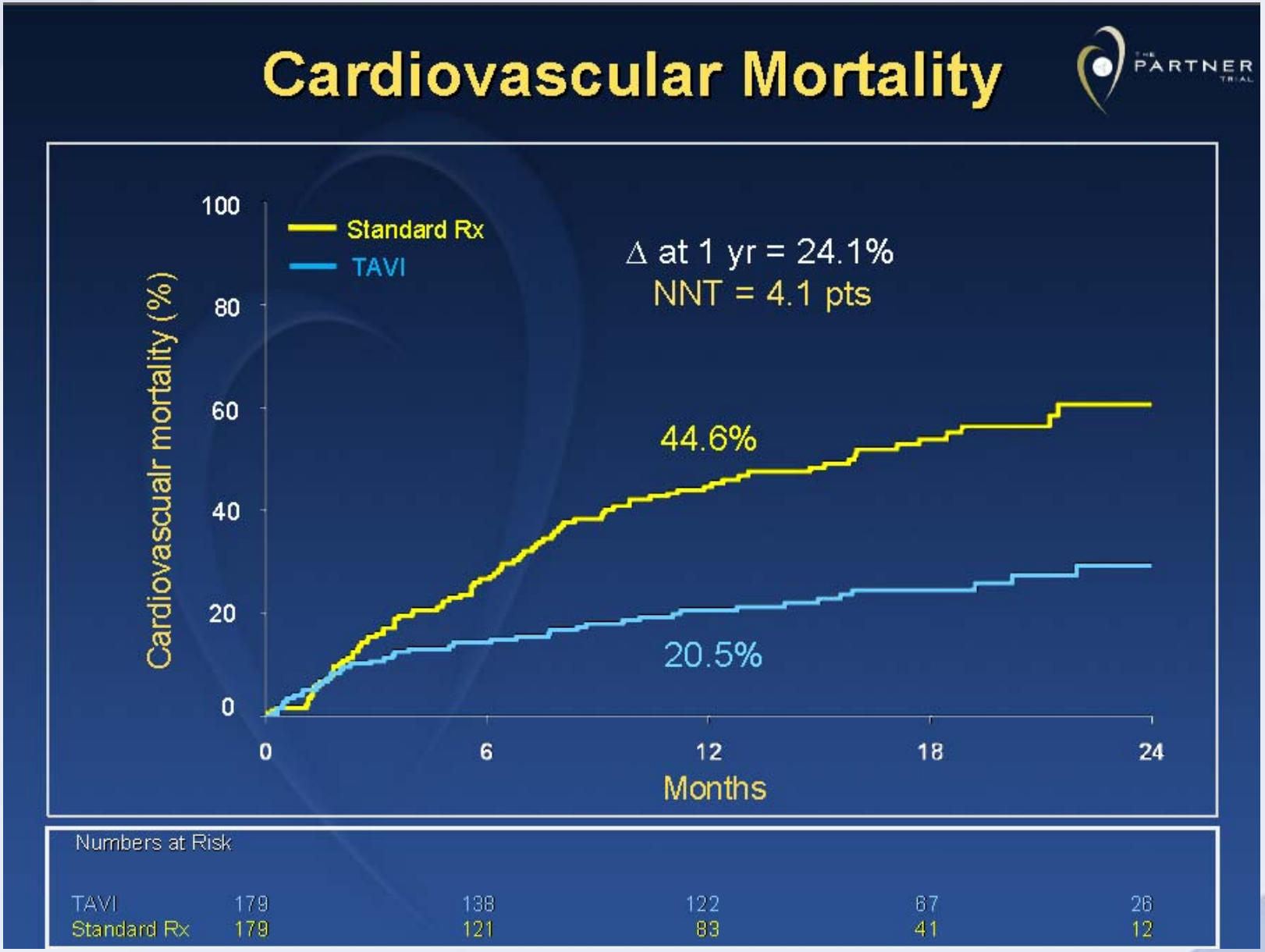
NEJM sept 22, 2010

Partner Trial



NEJM sept 22, 2010

Partner Trial



NEJM sept 22, 2010

ACC/i2 2010

EVEREST II

Endovascular Valve Edge-to-Edge REpair Study (EVEREST II)
Randomized Clinical Trial: Primary Safety and Efficacy Endpoints

Catheter-Based Mitral Valve Repair (MitraClip® System)

EVEREST II

Study Design

279 Patients enrolled at 37 sites

Significant MR (3+-4+)
Specific Anatomical Criteria

↓

Randomized 2:1

Device Group	Control Group
MitraClip System	Surgical Repair or Replacement
N=184	N=95

↓

Echocardiography Core Lab and Clinical Follow-Up:
Baseline, 30 days, 6 months, 1 year, 18 months, and annually through 5 years

ACC/i2 2010

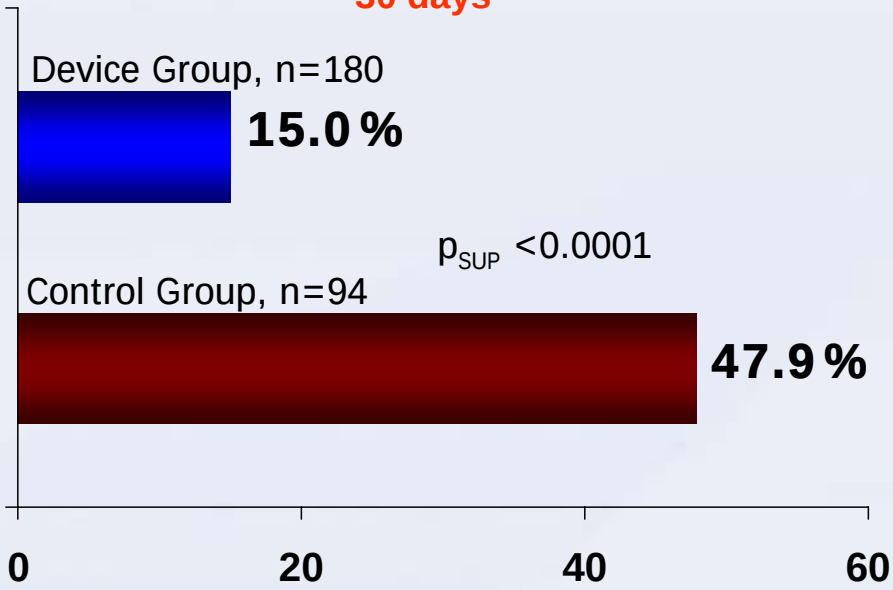
EVEREST II

Intention to Treat Cohort

Safety

Major Adverse Events

30 days



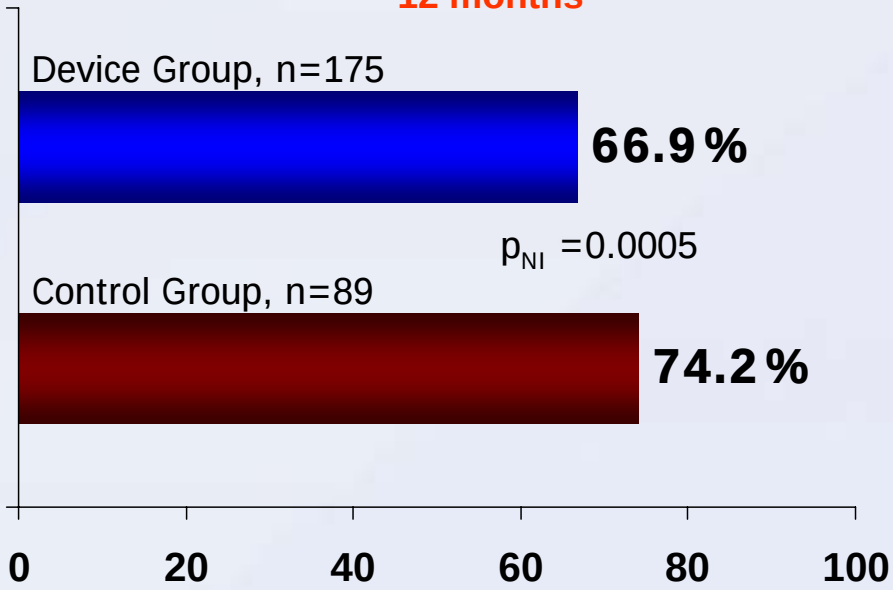
Met superiority hypothesis

- Pre-specified margin =2%
- Observed difference = **32.9 %**
- 97.5% LCB = 20.7%

Effectiveness

Clinical Success Rate*

12 months



Met non-inferiority hypothesis

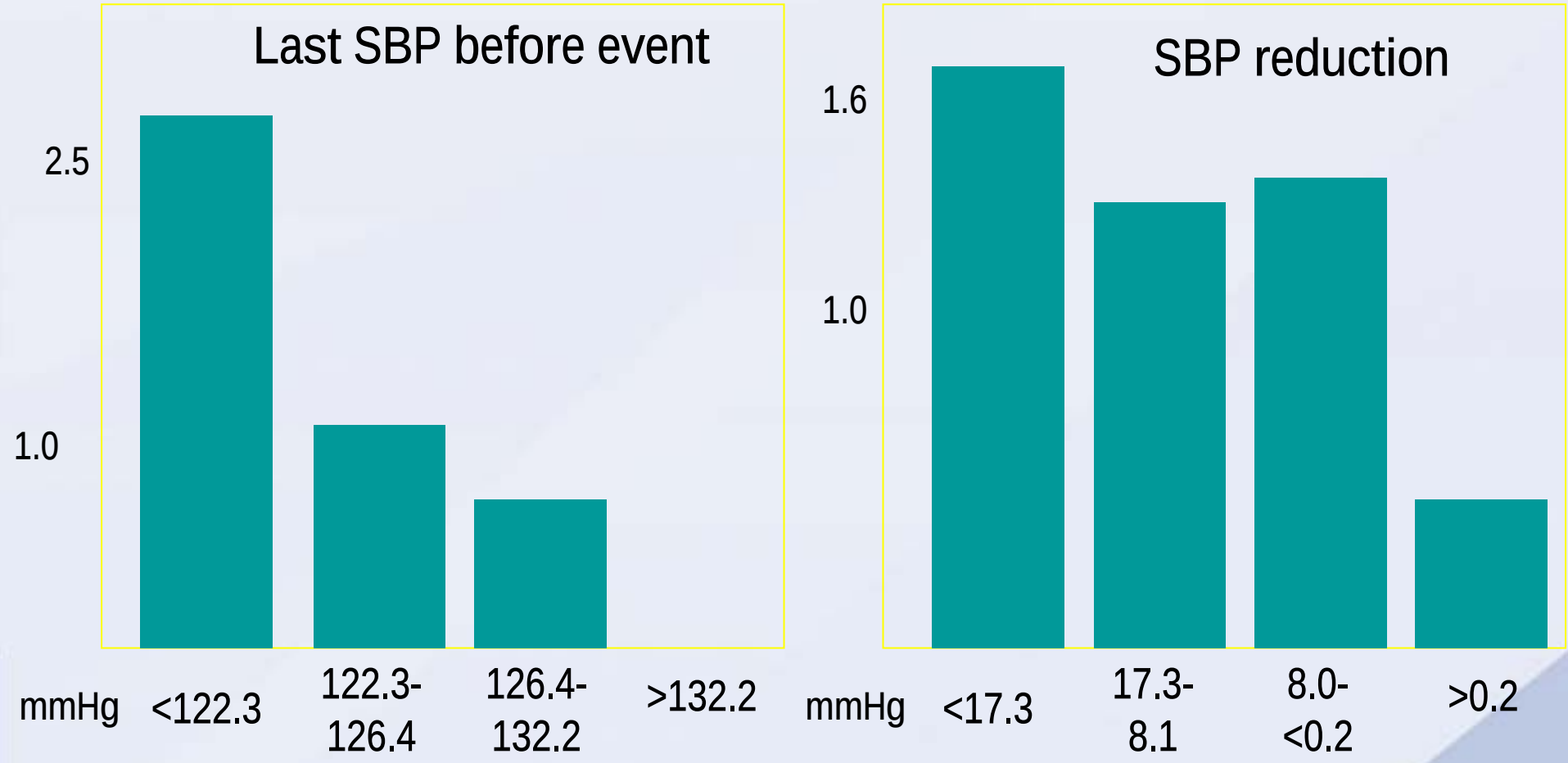
- Pre-specified margin = 25%
- Observed difference = **7.3 %**
- 95% UCB = 17.8%

Conclusiones

- Nuevas opciones terapéuticas en HTA
- Manejo de la C. Isquémica mas adaptado al medio.
- “Nuevos” fármacos en IC
- Menos estrictos en el control de la frecuencia cardiaca en FA permanente
- Nueva etapa de la anticoagulación.
- Mayor peso de procedimientos intervencionistas:
  - Ablación de la FA
  - Implante de Prótesis Aortica Percutanea
  - Clip Mitral

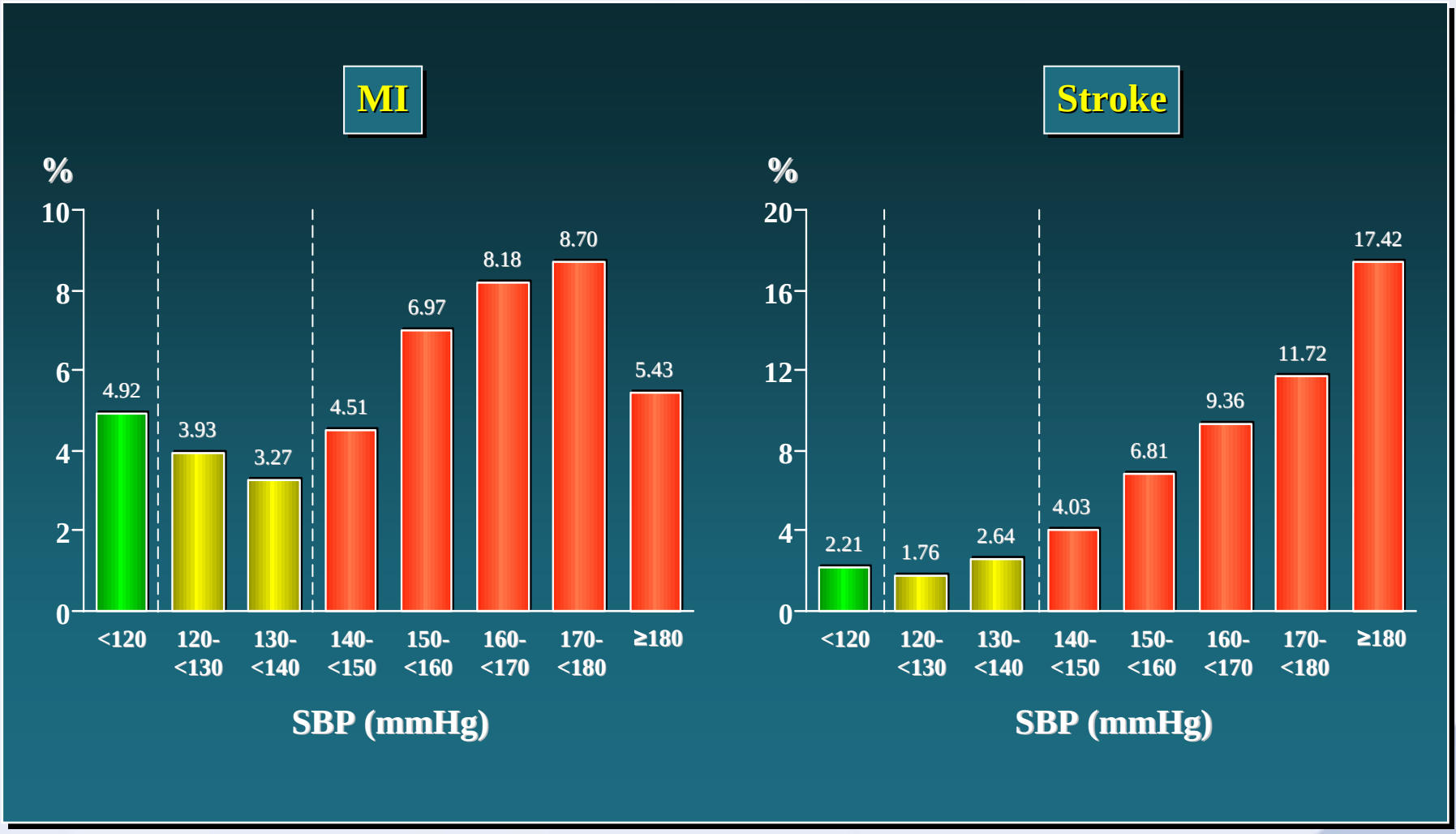

Y SE NOS VA ACABANDO EL AÑO NO MAS
JAMA
ASÍ ES
EL LANCET
¿CÓMO SERÁ EL AÑO QUE VIENE?
The NEW ENGLAND JOURNAL of MEDICINE
¡MUY VALIENTE PORQUE COMO ANDA LA COSA, ANIMARSE A VENIR!....
Circulation
QUINO

ROADMAP. Lowest SBP and/or highest SBP reduction quartile are associated with increased CV mortality in CHD patients. The "J" curve effect again



Cohort of patients with pre-existing CHD (1104)

CV Event Incidence in Relation to Mean FU Systolic BP (up to 1st event) in VALUE



Mancia et al., 2010