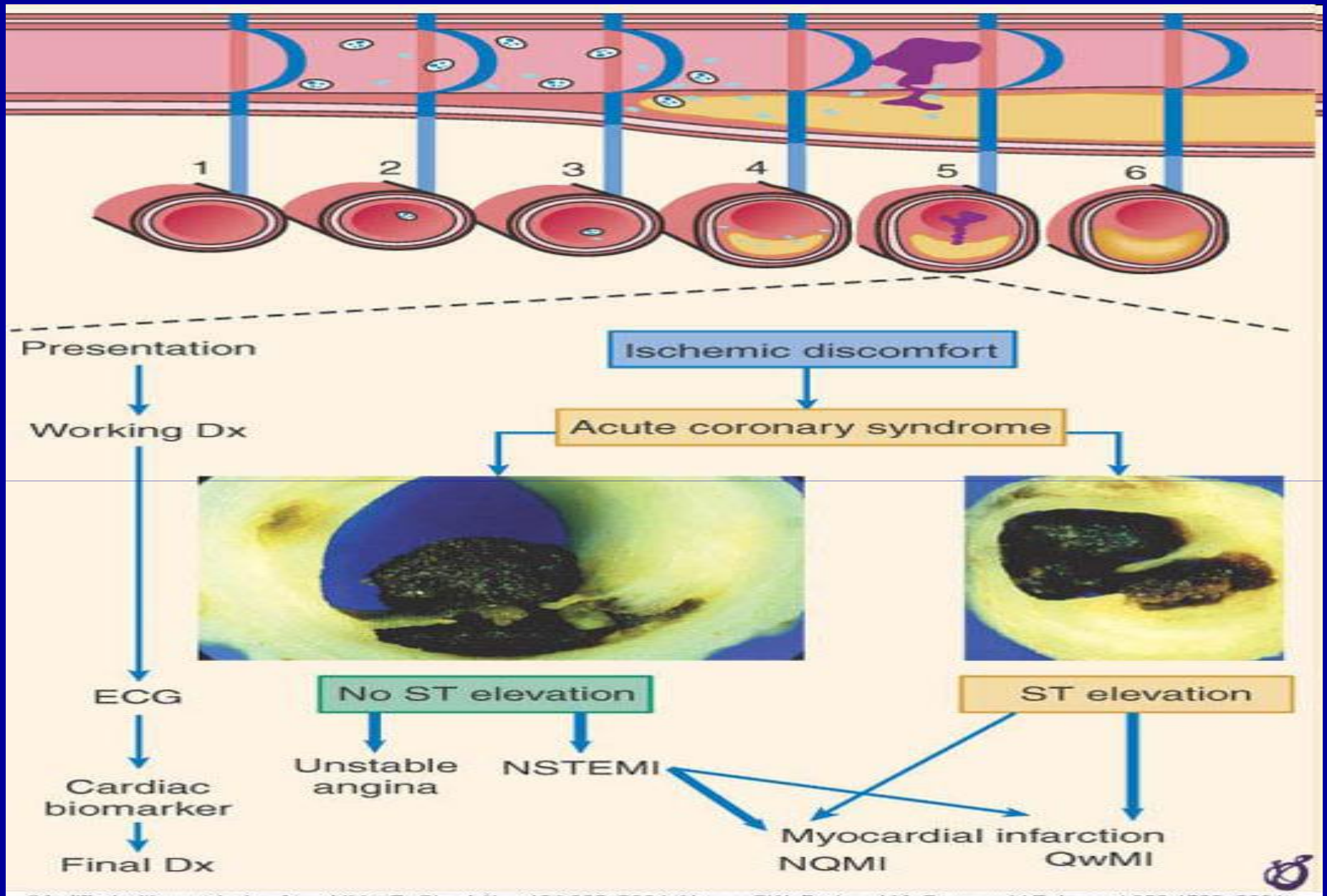
PATH Ο.Σ.Σ

ΣΠΥΡΟΜΗΤΡΟΣ ΓΕΩΡΓΙΟΣ
ΚΑΡΔΙΟΛΟΓΟΣ, FESC.
Ε.Α , ΥΠΕΥΘΥΝΟΣ ΚΑΡΔΙΟΛΟΓΙΚΗΣ ΚΛΙΝΙΚΗΣ
Γ.Ν.ΚΑΤΕΡΙΝΗΣ

PATH 1

- Ασθενείς που νοσηλεύθηκαν στην Κ/Δ κλινική κατά το χρονικό διάστημα ενός έτους με διάγνωση Ο.Ε.Μ και λήψη ασπιρίνης στη θεραπευτική τους αγωγή.



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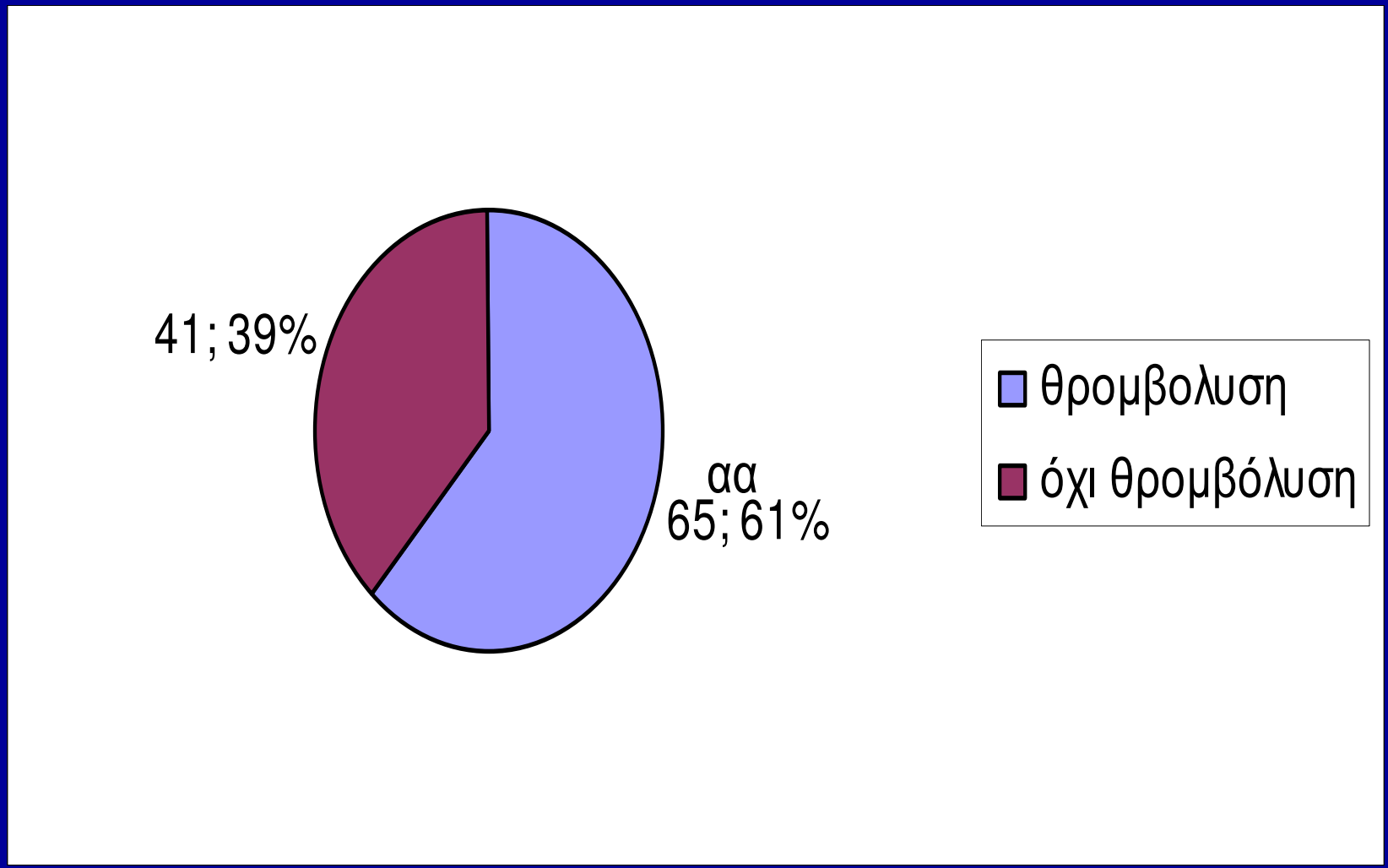
PATH 1

- 106 ΑΣΘΕΝΕΙΣ ΟΣΣ
- 65 STEMI (έλαβαν θρομβόλυση)
- 41 δεν έλαβαν θρομβόλυση.

Ασθενεις με Ο.Σ.Σ



PATH 1

- **Ολοι έλαβαν κατά την προσέλευση τους ασπιρίνη**
- Δόση φόρτισης 325 mg μασώμενη και εν συνεχεία 100 mg (salospir)
- Ποσοστό 100%

Doses of anti-platelet co-therapies

Doses of antiplatelet co-therapies	
With primary PCI	
Aspirin	Loading dose of 150-300 mg orally or of 80-150 mg i.v. if oral ingestion is not possible, followed by a maintenance dose of 75-100 mg/day.
Clopidogrel	Loading dose of 600 mg orally, followed by a maintenance dose of 75 mg/day.
Prasugrel	Loading dose of 60 mg orally, followed by a maintenance dose of 10 mg/day. In patients with body weight <60 kg, a maintenance dose of 5 mg is recommended. In patients > 75 years, prasugrel is generally not recommended, but a dose of 5 mg should be used if treatment is deemed necessary.
Ticagrelor	Loading dose of 180 mg orally, followed by a maintenance dose of 90 mg b.i.d.
Abciximab	Bolus of 0.25 mg/kg i.v. and 0.125 µg/kg/min infusion (maximum 10 µg/min) for 12 h.
Eptifibatide	Double bolus of 180 µg/kg i.v. (given at a 10-min interval) followed by an infusion of 2.0 µg/kg/min for 18 h.
Tirofiban	25 µg/kg over 3 min i.v., followed by a maintenance infusion of 0.15 µg/kg/min for 18 h.
With fibrinolytic therapy	
Aspirin	Starting dose 150-500 mg orally or i.v. dose of 250 mg if oral ingestion is not possible.
Clopidogrel	Loading dose of 300 mg orally if aged ≤ 75 years, followed by a maintenance dose of 75 mg/day.
Without reperfusion therapy	
Aspirin	Starting dose 150-500 mg orally.
Clopidogrel	75 mg/day orally.

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doi:10.1093/eurheartj/ehs215

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Recommendations for oral antiplatelet agents (1)

Recommendations	Class	Level
Aspirin should be given to all patients without contraindications at an initial loading dose of 150-300 mg, and at a maintenance dose of 75-100 mg daily long-term regardless of treatment strategy.	I	A
A $P2Y_{12}$ inhibitor should be added to aspirin as soon as possible and maintained over 12 months, unless there are contraindications such as excessive risk of bleeding.	I	A
A proton pump inhibitor (preferably not omeprazole) in combination with DAPT is recommended in patients with a history of gastrointestinal haemorrhage or peptic ulcer, and appropriate for patients with multiple other risk factors *(H. elicobacter pylori* infection, age ≥ 65 years, concurrent use of anticoagulants or steroids).	I	A
Prolonged or permanent withdrawal of $P2Y_{12}$ inhibitors within 12 months after the index event is discouraged unless clinically indicated.	I	C
Ticagrelor (180 mg loading dose, 90 mg twice daily) is recommended for all patients at moderate-to-high risk of ischaemic events (e.g. elevated troponins), regardless of initial treatment strategy and including those pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced).	I	B
Prasugrel (60 mg loading dose, 10 mg daily dose) is recommended for $P2Y_{12}$-inhibitor-naïve patients (especially diabetics) in whom coronary anatomy is known and who are proceeding to PCI unless there is a high risk of life-threatening bleeding or other contraindications.	I	B

European Heart Journal (2011) 32:2999–3054
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PATH 2

- Θνητότητα των ασθενών που νοσηλεύθηκαν στην Κ/Δ κατά το χρονικό διάστημα ενός έτους με διάγνωση Ο.Ε.Μ
- 106 ΑΣΘΕΝΕΙΣ ΟΣΣ
- 65 STEMI (έλαβαν θρομβόλυση)
- 41 δεν έλαβαν θρομβόλυση.

PATH 2

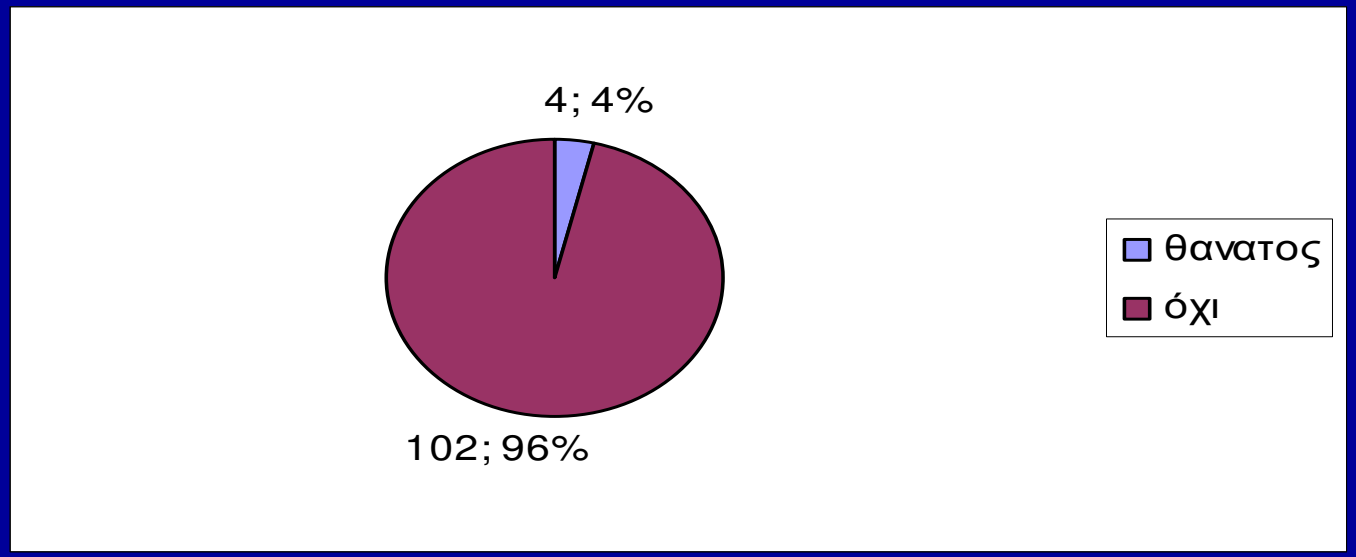
- 22 ΔΙΑΚΟΜΙΔΗ (106)

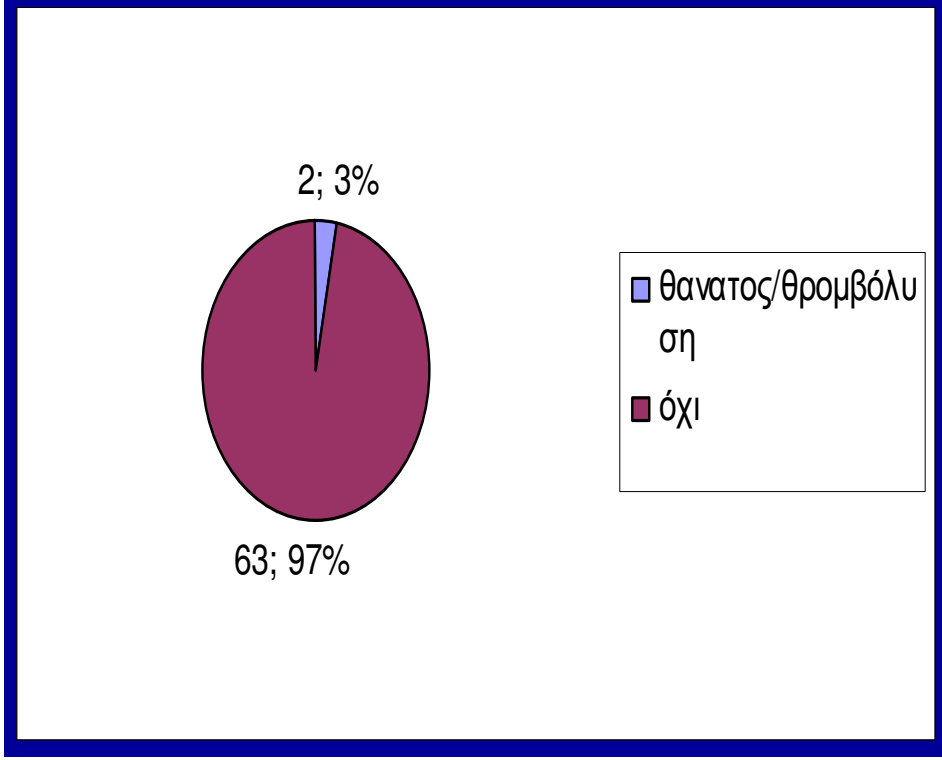
- **Απεβίωσαν στην μονάδα**
- Θρομβόλυση : 2 (65)
- Χωρίς θρομβόλυση: 2 (41)

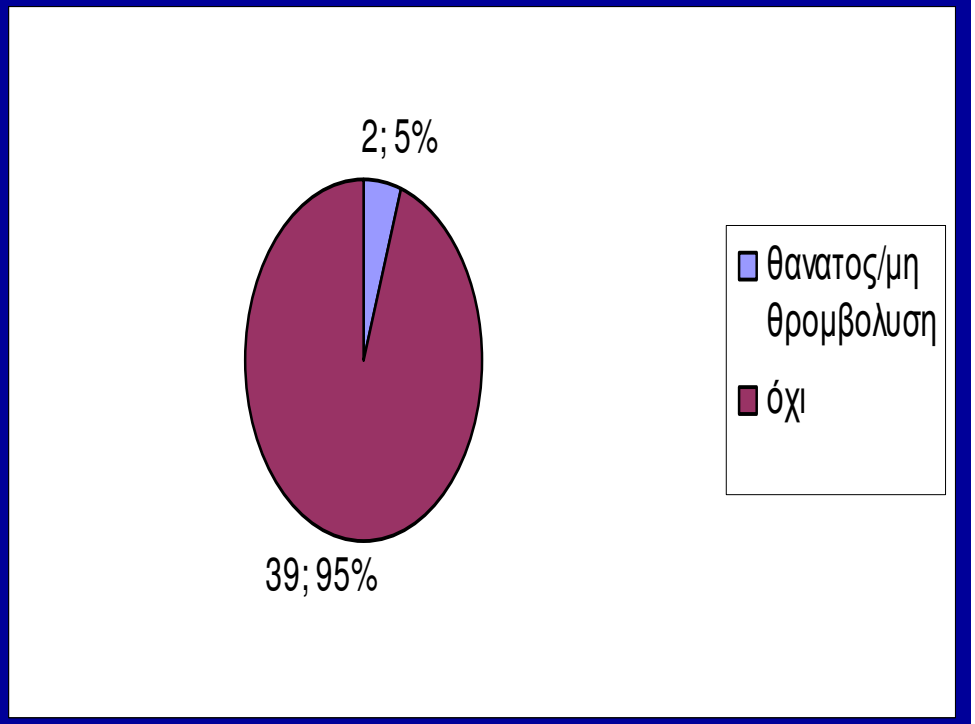
- **Εκτός νοσοκομείου**: 1

PATH 2

- Θνητότητα συνολική 4.7%
- Ενδονοσοκομειακή 3.7%
- Θρομβόλυση 3.07%
- Χωρίς θρομβόλυση 4.8%


4; 4%
102; 96%
θανατος
όχι


2; 3%
63; 97%
θανατος/θρομβόλυση
όχι


2; 5%
39; 95%
θανατος/μη θρομβολυση
όχι

ESC survey of acute coronary syndromes, European Heart Journal (2002) ***23, 1190–1201***

A prospective survey of the characteristics, treatments and outcomes of patients with acute coronary syndromes in Europe and the Mediterranean basin

The Euro Heart Survey of Acute Coronary Syndromes (Euro Heart Survey ACS)

D. Hasdai1, S. Behar2, L. Wallentin3, N. Danchin4, A. K. Gitt5, E. Boersma6, P. M. Fioretti7, M. L. Simoons6 and A. Battler1

1*Rabin Medical Center, Petah Tikva, Israel; 2Neufeld Cardiac Research Institute, Tel Hashomer, Israel;*
3*University Hospital, Uppsala, Sweden; 4CHU de Nancy-Brabois, Vandoeuvre, France; 5Klinikum der Stadt*
Ludwigshafen, Germany; 6Thoraxcentre, Rotterdam, Netherlands; 7Ospedaliera S. Maria della Misericordia, Udine,

ESC survey of acute coronary syndromes, European Heart Journal (2002) ***23, 1190–1201***

In-hospital and 30-day mortality based on initial diagnosis

In-hospital survival status was available for all patients, **with a mean in-hospital death rate of 4·9% for** the entire survey cohort. The in-hospital death rate for patients with ST elevation ACS was 7·0%, for patients without ST elevation ACS 2·4%, and for patients with an undetermined initial electrocardiographic pattern 11·8%.

At 30 days, the death rates were **8·4%,** 3·5%, and 13·3%, respectively (with 30-day survival status available for 90·7%, 88·8%, and 88·6%, respectively), resulting in a mean 30-day death rate for the entire cohort of 6·3%.


AT THE GASLAMP
EXOTIC DRINKS