

Study: AHA guidelines to treating patients with coronary artery disease

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The most recent dual antiplatelet guidelines from the American Heart Association and the American College of Cardiology encourage healthcare providers to take a customized approach to treating patients with coronary artery disease. Healthcare providers can find out more about the latest best practices for using dual antiplatelet therapy by going to www.heart.org/amitoolkit.

The guidelines update recommendations in six previously published treatment guidelines, including those for bypass graft surgery, catheter-placed stents and myocardial infarction [patients](#). The comprehensive new version reflects today's best practices for using aspirin combined with P2Y12 receptor inhibitors clopidogrel, prasugrel or ticagrelor. It includes a review of 11 studies of patients treated with coronary stent implantation done predominately with drug-eluting stents, to assess the risks and benefits of shorter-versus longer-duration dual antiplatelet therapy.

"With drug-eluting stents, which represent one of the most common types of the [stents](#) used today, we have better outcomes, with lower risk of restenosis. But the downside is we have to use dual antiplatelet therapies for much longer," said John A. Osborne, M.D., Ph.D., a cardiologist at State of the Heart Cardiology in Dallas.

Newer longer-term studies have helped to clarify optimal durations of dual antiplatelet therapy for specific patients, according to Osborne.

"One of the big questions among providers has been: What is the benefit, versus the harm, of long-term therapy?" said Osborne. "The guidelines suggest that longer term therapy may be reasonable for certain individuals, including those who are at lower risk of bleeding, because we are seeing further reduction of cardiovascular events with prolonged use of these drugs."

Studies looking at prolonging dual antiplatelet therapy for an additional 18 or 48 months have found decreased risks of heart attack and stent thrombosis, but increased bleeding risk.

To get the best outcomes, providers must weigh the patient's bleeding risk into the equation, according to Osborne.

The good news is that patients who are at generally lower risk of subsequent events but higher bleeding risk have fared well in studies looking at three to six months of dual antiplatelet therapy, compared with a standard 12 months of therapy. In appropriate patients, reducing the duration of dual antiplatelet therapy did not increase stent thrombosis risk and resulted in fewer bleeding complications.

The authors recommend shorter-duration dual antiplatelet therapy in patients treated with "newer-generation," versus "first-generation," [drug-eluting stents](#).

The key for providers, according to Osborne, is individualization. For example, patients at higher than average cardiovascular risk, who appear to have a low bleeding risk, benefit from not only continued efforts at risk factor modification but also may benefit from prolonged dual antiplatelet therapy treatment, he said. To help with those risk assessments, the guidelines provide lists of factors that increase clotting and heart attack risk, as well as increase bleeding risk.

The update also addresses such things as aspirin use, recommending most patients remain on a dose of 81 mg aspirin daily indefinitely after dual antiplatelet therapy.

It's important for providers to take notice of the changes in the latest dual [antiplatelet therapy](#) update because the recommendations impact the quality of care for many among the roughly 16.5 million Americans with coronary heart disease.

"Guidelines always change according to the latest science. We want to make sure that providers are informed of the latest data, and how it ultimately will have the best impact for our patients," Osborne said.

Provided by American Heart Association

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