Guide de pratique en MAP, du cœur aux pieds
Consensus canadien 2022 - SSVQ 2023

OBJECTIFS

- Choisir le meilleur traitement pour les lipides, le diabète et l'HTA
- Sélectionner la meilleure approche anti-plaquettaire
- Intégrer le programme de marche

André Roussin MD, FRCP
CHUM Professeur agrégé, Université de Montréal

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Thrombosis Canada
Thrombose Canada

SSVQ Société des sciences vasculaires du Québec

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Maladie artérielle périphérique (MAP)
Consensus canadien 2022
Conflits d'intérêts potentiels 2020-2023

Co-auteur
Consensus canadien 2022 sur la MAP

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Traitements médicaux pour la MAP
Recommandations CCS 2022

CLASSES
Statines, selon Consensus Canadien 2021
Inh. ECA ou BRA si hypertension
Inh. SGLT-2 > Agoniste GLP-1 ou inh. DPP-4 (avec metformine)
Antiplaquettaires si symptomatique
Médicaments anti-tabagiques

Hypolipémiants et MAP

12. We recommend that patients with PAD qualify as statin-indicated patients and should receive lipid-modifying therapy for the reduction of death, CV death, nonfatal MI, nonfatal stroke (MACE), and MALE concordant with the recommendations in the 2021 Canadian Cardiovascular Society (CCS) guidelines for the management of dyslipidemia[42] (Strong Recommendation; High-Quality Evidence).
    a. Maximally tolerated dose of statin therapy
    b. Statin add-on therapies (ezetimibe and/or PCSK-9 inhibitors) if receiving maximally tolerated dose of statin therapy and the low-density lipoprotein cholesterol is $\geq$ 1.8 mmol/L, non-high-density lipoprotein cholesterol $\geq$ 2.4 mmol/L or apolipoprotein B_{100} $\geq$ 0.7 mg/dL.

Diabète et MAP

10. We recommend that patients with PAD and type 2 diabetes should be offered a SGLT-2 inhibitor compared with usual diabetic control because of the reduction in MACE without any risk of increased amputation (Strong Recommendation; High-Quality Evidence).
11. We suggest that patients with PAD and diabetes might benefit from use of a GLP-1 agonist or DPP-4 inhibitor (Weak Recommendation; Low-Quality Evidence).

Hypertension et MAP

17. We recommend that PAD patients with hypertension be treated with ACE inhibitors or ARBs as the first choice in the absence of contraindications (Strong Recommendation; Moderate-Quality Evidence).

A theoretical risk exists with the use of β-blockers in patients with limb ischemia. Previous guidelines have suggested avoiding the use of β-blockers in those with severe PAD. However, large systematic reviews on the topic have not shown increased harm with the use of β-blockers among patients with PAD. As such, they are not contraindicated and might be useful in PAD patients with concomitant CV disorders, where they are indicated as a second-line option.[59,60]

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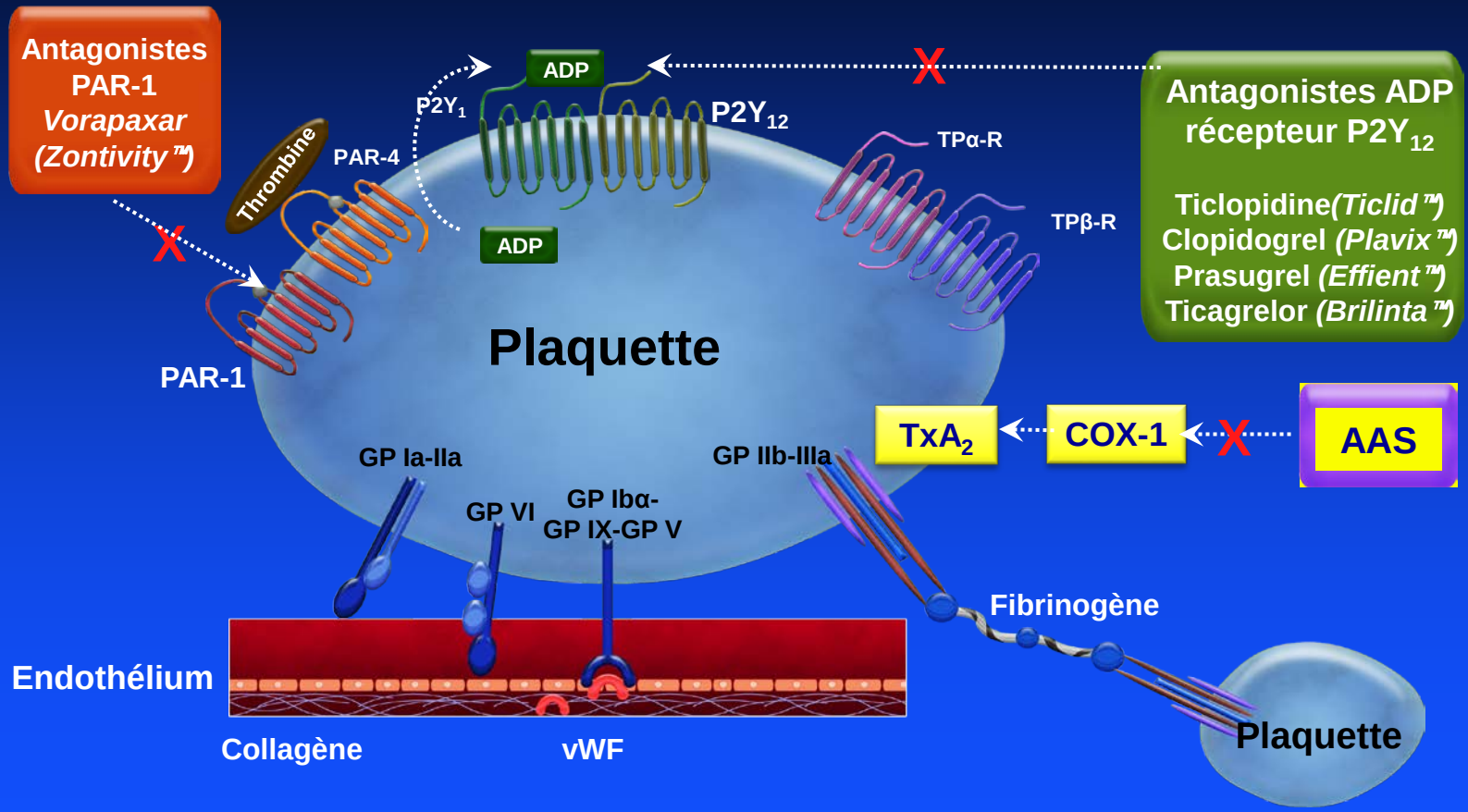
Tabagisme et MAP

7. We recommend smoking cessation to prevent PAD, and to prevent MACE and MALE in patients with PAD (Strong Recommendation; Moderate-Quality Evidence).
8. We recommend smoking cessation interventions ranging from intensive counselling, NRT, bupropion, varenicline, and sometimes nicotine EC (Strong Recommendation; High-Quality Evidence).

Antiplaquettaires oraux 2023 (Canada)

Bloqueurs TxA2, ADP ($P2Y_{12}$) et PAR-1



Adapté, modifié, traduit et mis-à-jour à partir de: Angiolillo DJ et al. European Heart Journal (2010) 31, 17–28

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Thérapie antithrombotique

Patients avec MAP asymptomatique isolée

18. We recommend **against** routine antithrombotic therapy (antiplatelet or anticoagulant) for patients with isolated asymptomatic lower extremity PAD (Strong Recommendation; High-Quality Evidence).

Thérapie antithrombotique

Combinaison rivaroxaban et AAS: patients à haut risque

19. We recommend treatment with rivaroxaban 2.5 mg twice daily in combination with aspirin (80-100 mg daily) for management of patients with symptomatic lower extremity PAD who are at high risk for ischemic events (high-risk comorbidities such as polyvascular disease, diabetes, history of heart failure, or renal insufficiency) and/or high-risk limb presentation post peripheral revascularization, limb amputation, rest pain, ischemic ulcers) and at low bleeding risk (Strong Recommendation; High-Quality Evidence).

Thérapie antithrombotique

Combinaison rivaroxaban et AAS: patients à “bas” risque

20. We recommend combination treatment with rivaroxaban 2.5 mg twice daily and aspirin or single antiplatelet therapy for patients with symptomatic lower extremity PAD and low bleeding risk in the absence of high-risk limb presentation or high-risk comorbidities (Strong Recommendation; High-Quality Evidence).

Thérapie antithrombotique
Si risqué élevé de saignement

21. We recommend single antiplatelet therapy with either aspirin (75-325 mg) or clopidogrel (75 mg) be considered for patients with symptomatic lower extremity PAD at high bleeding risk who remain eligible for antithrombotic therapy (Strong Recommendation; High-Quality Evidence).

Thérapie antithrombotique
Monothérapie

22. We suggest that clopidogrel (75 mg daily)[61] should be the preferred agent when single antiplatelet therapy is deemed to be the optimal antithrombotic choice (Weak Recommendation; Moderate-Quality Evidence).

Thérapie antithrombotique
Bi-thérapie si contre-indication au rivaroxaban

23. We suggest that dual antiplatelet therapy (DAPT; aspirin and clopidogrel or aspirin and ticagrelor) be used for patients with symptomatic lower extremity PAD at high risk for vascular events, at low bleeding risk, and who have contraindications to rivaroxaban (Weak Recommendation; Moderate-Quality Evidence).

Thérapie antithrombotique
Après une intervention

25. We recommend rivaroxaban 2.5 mg twice daily in combination with aspirin (80-100 mg daily), with or without short-term clopidogrel use, for patients with lower extremity PAD after elective endovascular revascularization (Strong Recommendation; Moderate-Quality Evidence).
26. We recommend treatment with rivaroxaban 2.5 mg twice daily in combination with aspirin (80-100 mg daily) for patients with lower extremity PAD after elective open revascularization (Strong Recommendation; High-Quality Evidence).

Exercice pour la claudication

30. We recommend supervised exercise programs as first-line therapy for patients with PAD and intermittent claudication, with the objective of improving maximal and pain-free walking distance and time, as well as quality of life (Strong Recommendation; High-Quality Evidence).

CONCLUSION: Approche de la MAP en 2023

- Médication de base:
  - Antiplaquettaires si symptomatique
    - Combinaison rivaroxaban /AAS à considérer
  - Statines selon le consensus canadien lipides 2021
  - IECA ou BRA en priorité si HTA
- Programme de marche efficace
- Les approches endovasculaires et chirurgicales dépendent du degré d'atteinte fonctionnelle

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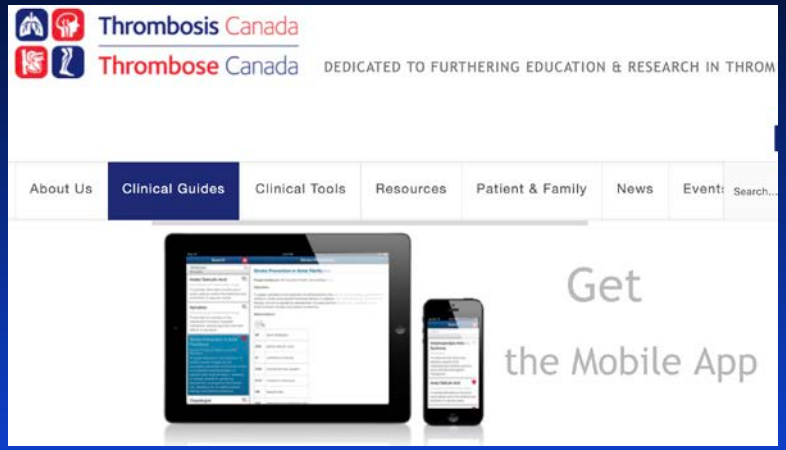
RÉFÉRENCES



SSVQ Société des sciences vasculaires du Québec
Chef de file en santé vasculaire.

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