

NAPOLI, 17-20 maggio 2017

XXI CONGRESSO
NAZIONALE

AMD

AMD

ASSOCIAZIONE
MEDICI
DIABETOLOGI

1974
ANNO DI FONDAZIONE



PER UNA DIABETOLOGIA PREDITTIVA, PREVENTIVA, PERSONALIZZATA E PARTECIPATIVA

La rivascularizzazione del paziente diabetico con sindrome coronarica acuta

Fortunato Scotto di Uccio

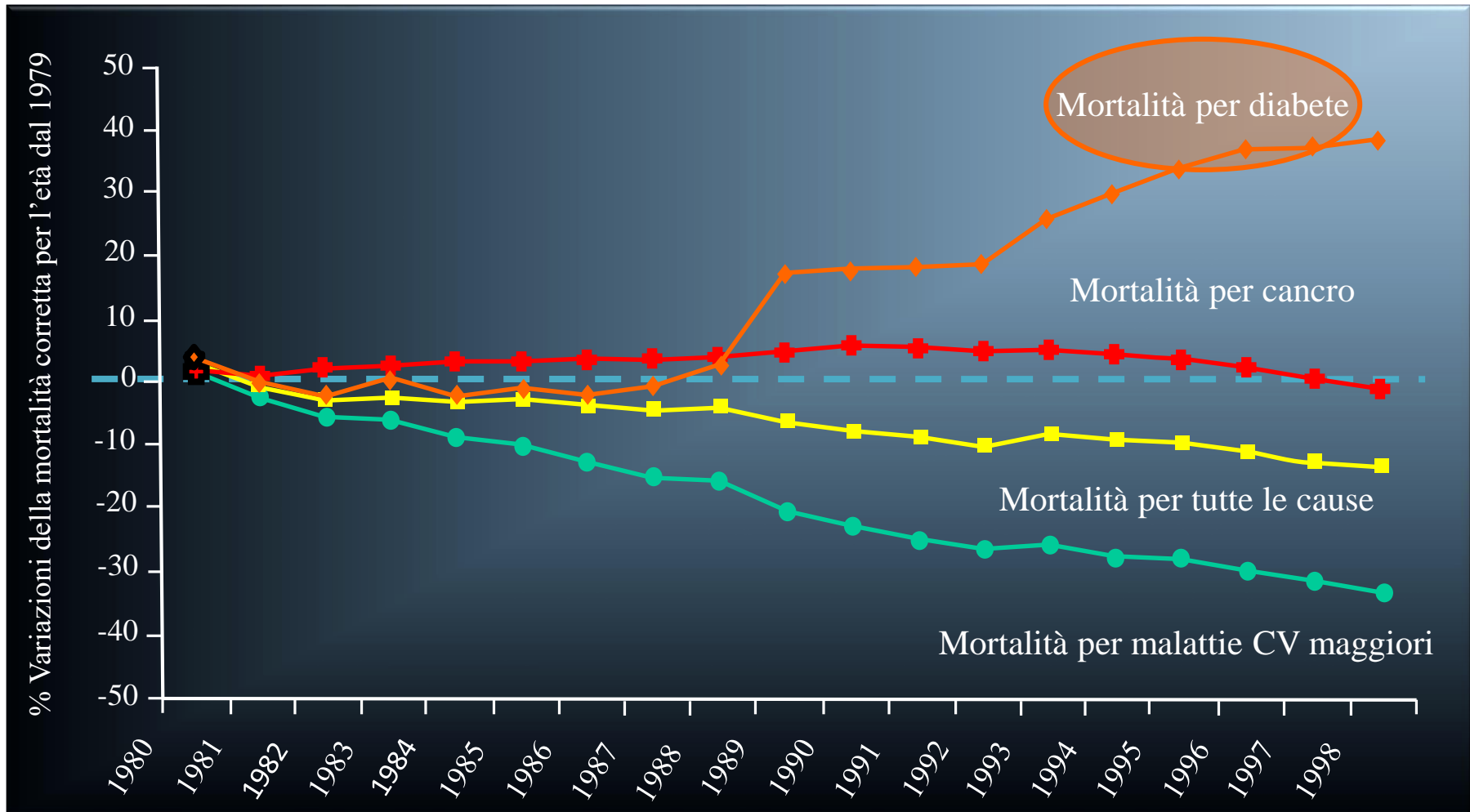
Consiglio Direttivo Nazionale ANMCO

Cardiologia UTIC – Emodinamica, O. Loreto Mare ASL NA 1

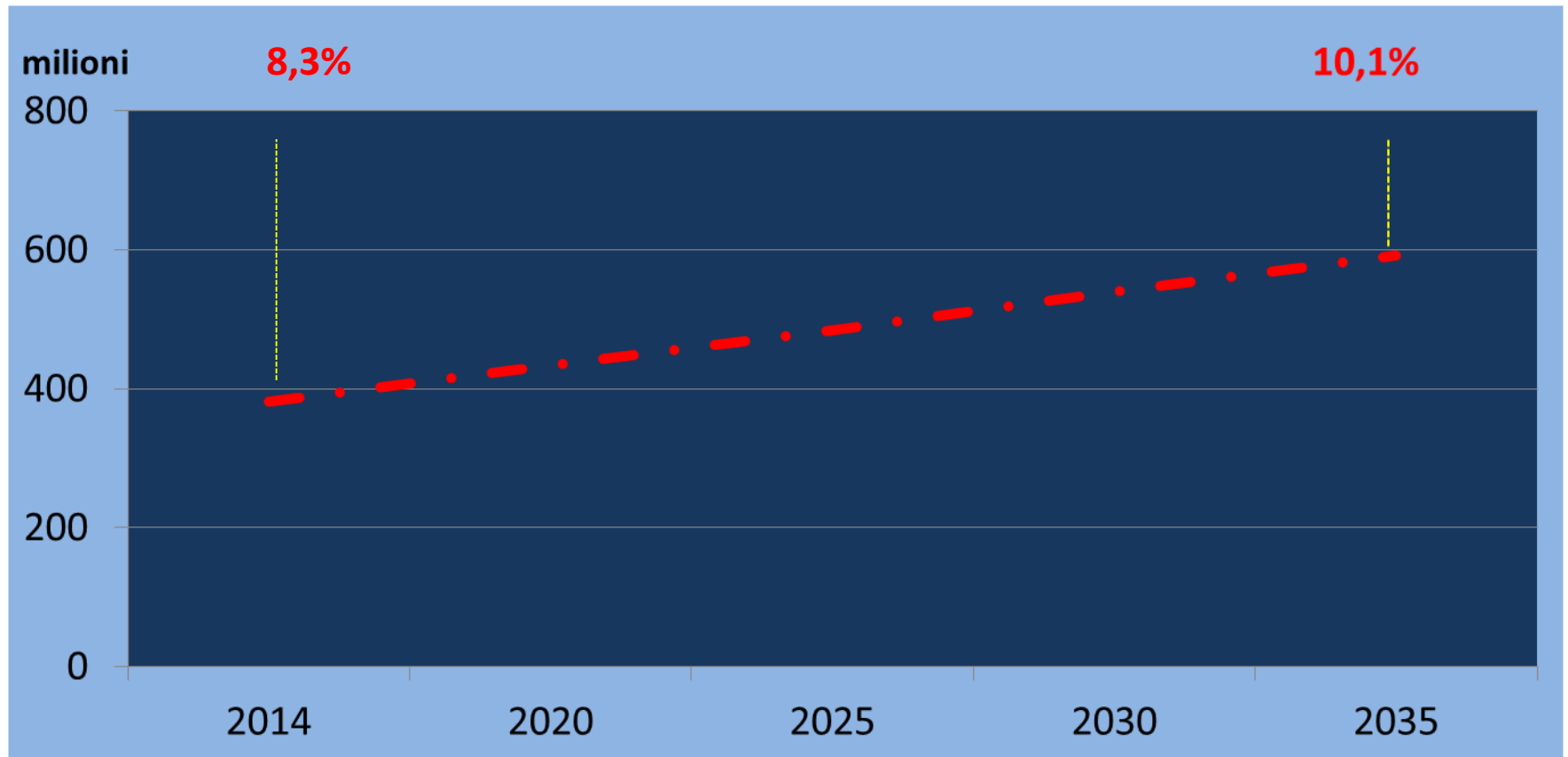
Diabete & Sindrome Coronarica Acuta (SCA)

- Il paziente diabetico = non diabetico?
- Qual è la migliore strategia terapeutica farmacologica?
- Qual è la migliore strategia terapeutica di rivascularizzazione?

Diabete e Mortalità



Prevalenza del Diabete Mellito nel mondo



Diabete Mellito in Italia

- 2.960.000 di individui
- 4,9% della popolazione totale
- 5,2% donne – 4,5% uomini

60%

*Sviluppa una
malattia
cardiovascolare*

30%

*Dei pazienti con
SCA è Diabetico*



Baseline Clinical Characteristics



	Overall n= 2585	STEMI n= 1066	NSTE-ACS n= 1519
Age, yrs (mean±SD)	69±13	66±13	70±12
≥75 yrs old, n (%)	929 (35.9)	308 (28.9)	621 (40.9)
Female, n (%)	796 (30.8)	299 (28.1)	497 (32.7)
BMI (mean±SD)	27±4	27±4	27±4
Risk factors and comorbidities, n (%)			
Familiar history of CAD *	662 (31.2)	276 (29.8)	386 (32.4)
Active smokers	745 (28.8)	405 (38.0)	340 (22.4)
Dyslipidemia*	1163 (51.0)	381 (41.4)	782 (57.5)
Diabetes mellitus	733 (28.4)	223 (20.9)	510 (33.6)
Hypertension	1739 (67.3)	620 (58.2)	1119 (73.7)
Renal dysfunction/dyalisis	379 (14.7)	90 (8.4)	289 (19.0)
Severe COPD	152 (5.9)	54 (5.1)	98 (6.5)
Malignancy	57 (2.2)	22 (2.1)	35 (2.3)

Diabete & Sindrome Coronarica Acuta (SCA)

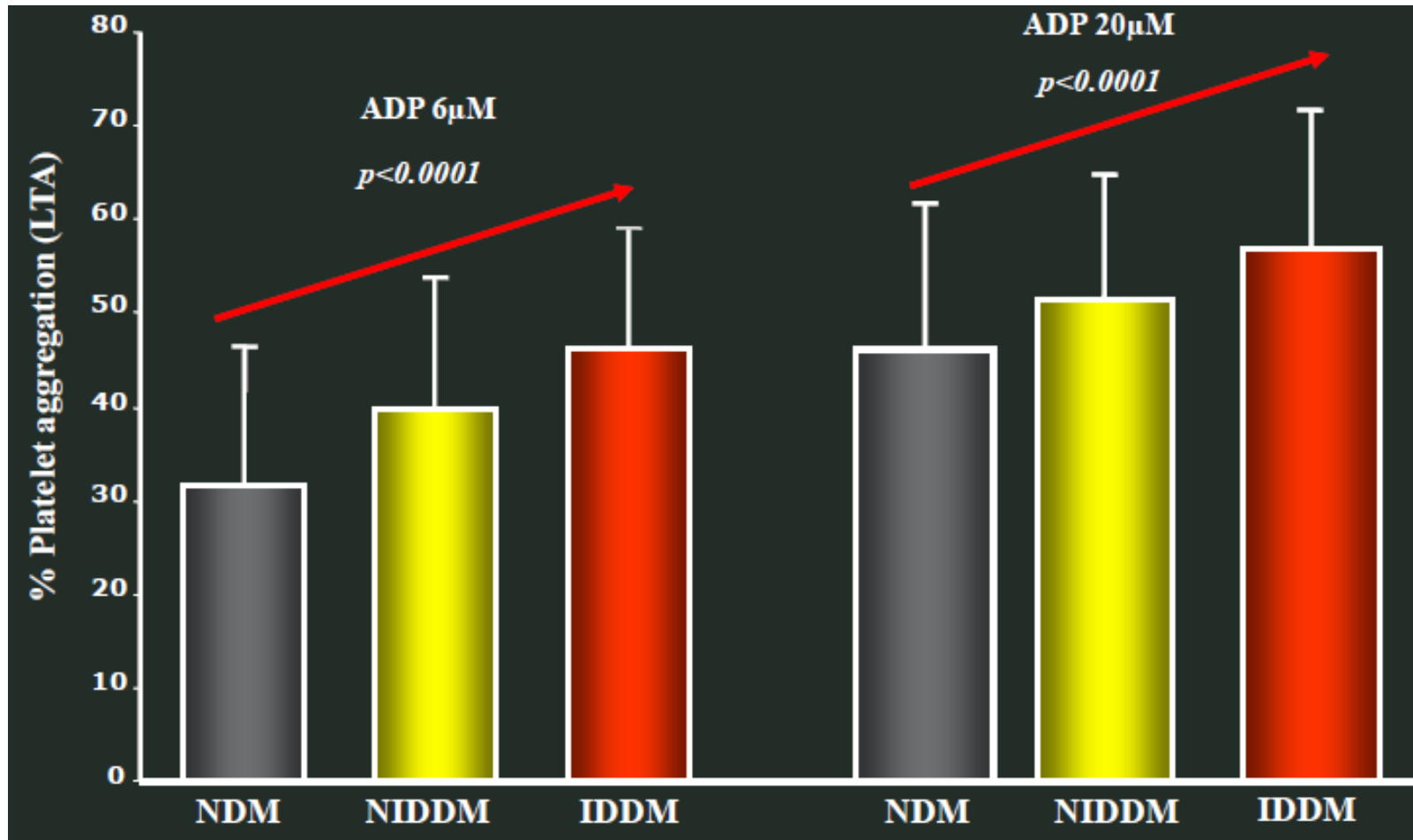
- **Il paziente diabetico = non diabetico?**
- Qual è la migliore strategia terapeutica farmacologica?
- Qual è la migliore strategia terapeutica di rivascularizzazione?

Diabete e terapia antiaggregante

Nel paziente diabetico con SCA:

1. 1- Le piastrine sono disfunzionanti
2. 2- La disfunzione piastrinica si associa ad un aumento del rischio aterotrombotico

Platelet Function According to Hypoglycemic Treatment



SCA e Diabete: “*Uno stato protrombotico*”

Alterazione della Fibrinolisi

↑ PAI-1, a2-antiplasmina
↓ t-PA

Alterazione della funzione piastrinica

↑ adesione, aggregazione & attivazione
(GP IIb/IIIa, Psel, CD40L)

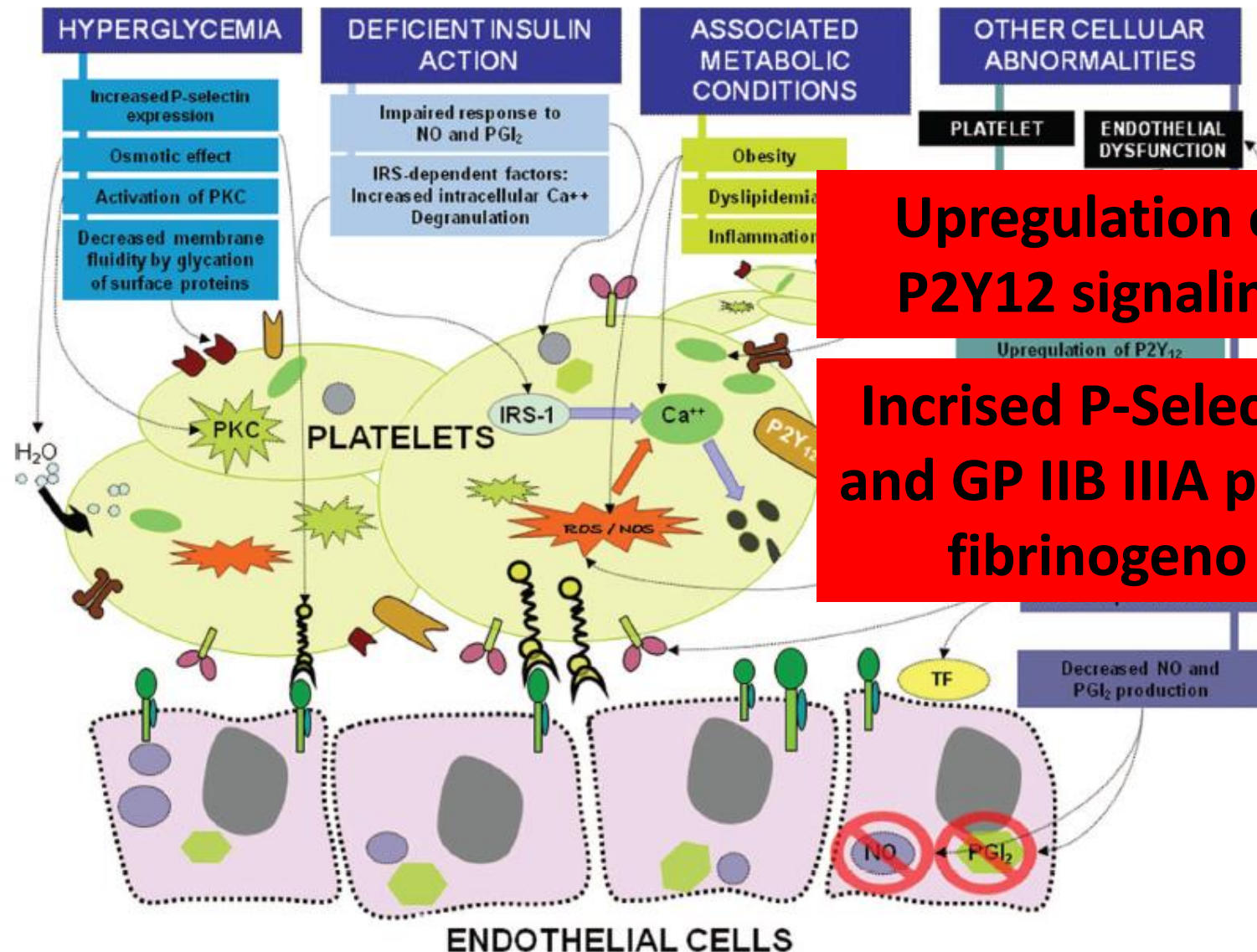
TROMBOSI

Alterazione della coagulazione

↑ Fibrinogeno
↑ vWF
↑ Trombina
↑ FVII, FVIII
↑ AT-III
↓ Eparine solfato

Disfunzione Endoteliale

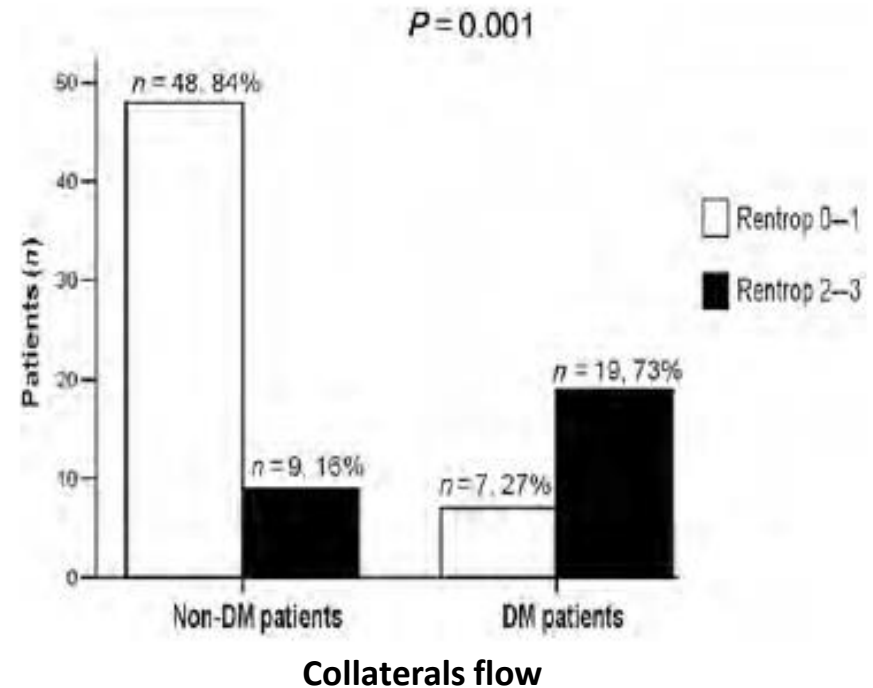
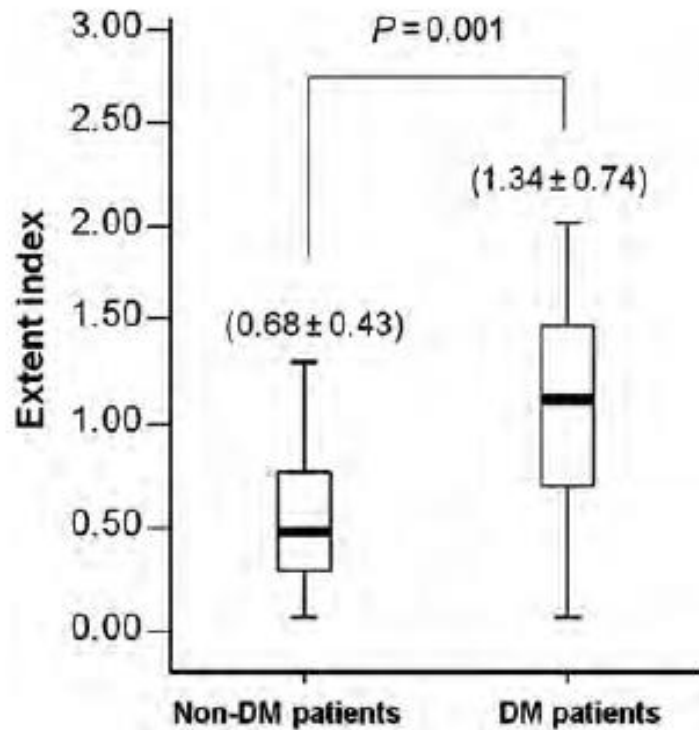
Molecole di adesione (VCAM, etc) ↑
Interazione leucocita-endotelio ↑
Stress ossidativo (induzione NFkB) ↑
Alterata Vasodilatazione(ET-1, NO) ↓
Alterazione della rigenerazione endoteliale ↑



Upregulation of P2Y12 signaling

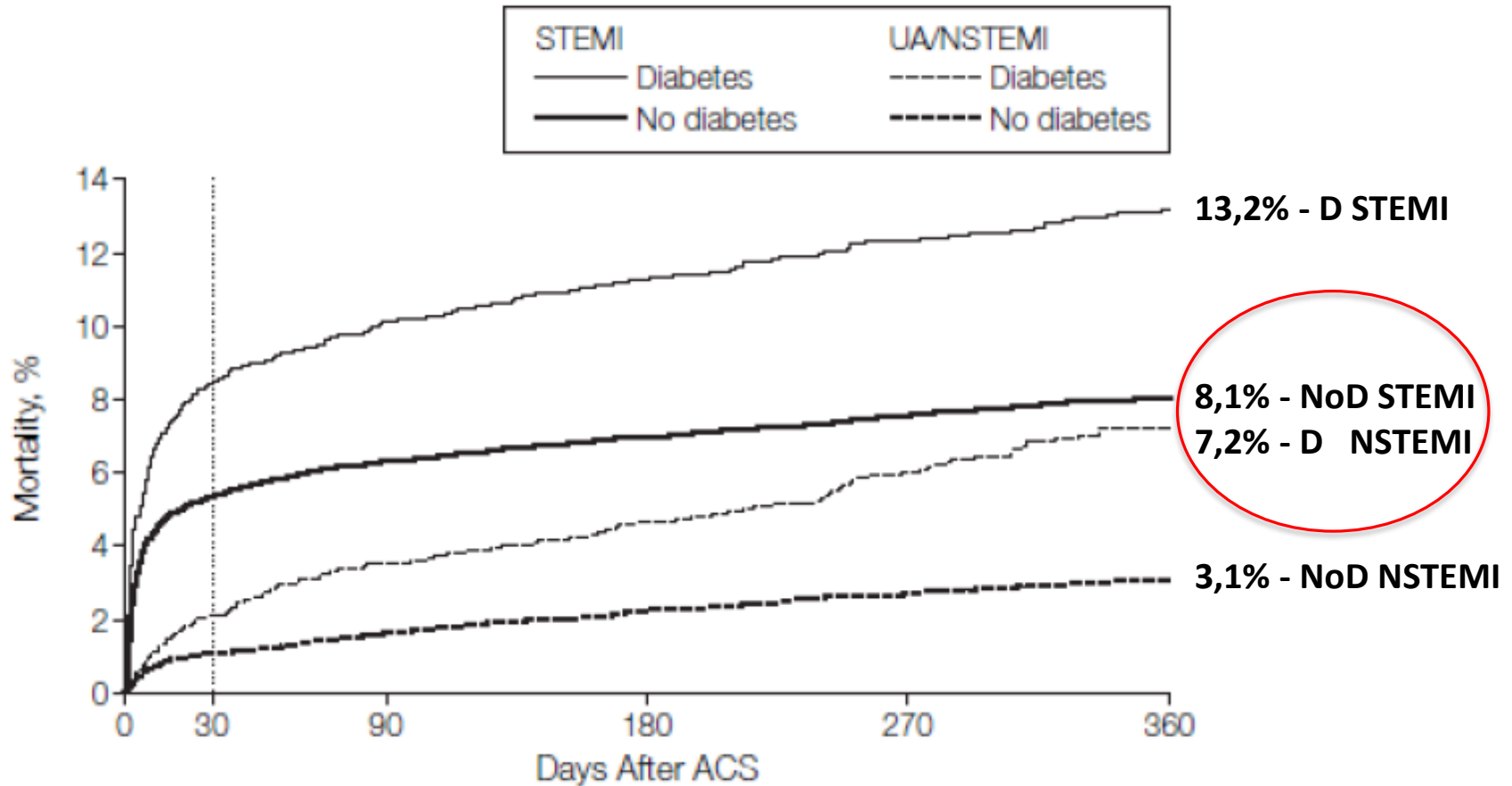
Increased P-Selectin and GP IIB IIIA per il fibrinogeno

Severity of coronary atherosclerosis in patients with a first acute coronary event: a diabetes paradox



Multi-vessel Disease	42%	68%
Total occlusion	21%	38%

Mortalità dopo una SCA



Caso clinico

- Uomo di anni 56
- Familiarità per CAD
- Ipertensione arteriosa
- Diabete mellito tipo II NID
- Fumatore

- Dolore toracico remittente da circa 3 giorni
- Al ricovero dolore toracico persistente da circa 60 min.
- ECO : Acinesia infero-postero-laterale FE 45%

ID: 1781

21-09-2015 04:28:51

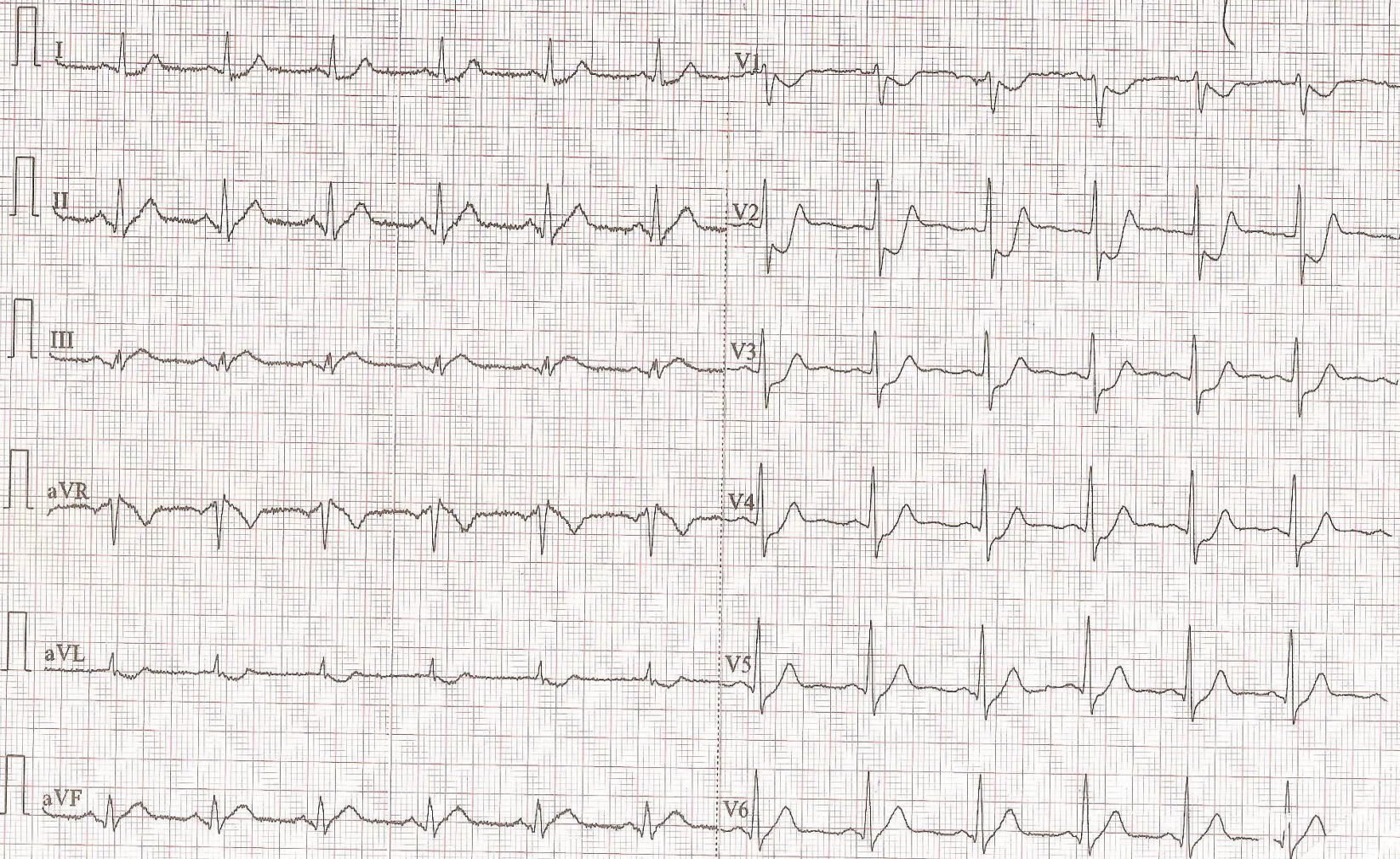
Anni *Piscopo Dorsica*
Reparto *03/02/1968*

HR : 79 bpm
P : 119 ms
PR : 150 ms
QRS : 109 ms
QT/QTc : 380/437 ms
P/QRS/T : 68/44/69 °
RV5/SV1 : 1.113/0.506 mV
RV5+SV1 : 1.619 mV
RV6/SV2 : 1.050/0.800 mV

Diagnosi:
800: Ritmo sinusale
661: Depressione ST lieve(V4)
842: BEV

Fv. 82
SpO2 99%
PA 155/95

Refertato da:



Caso clinico

SNODO DECISIONALE 1:

- Terapia medica ottimale + Clopidogrel 600 mg x os e coronarografia entro 72 ore
- Terapia medica ottimale + Ticagrerol 180 mg x os e coronarografia entro 72 ore
- Terapia medica ottimale + coronarografia urgente, e trattamento con P2Y12 dopo valutazione anatomia coronarica



EUROPEAN
SOCIETY OF
CARDIOLOGY®

2015 ESC guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Table 7 Criteria for high risk with indication for invasive management

Primary criteria

1. Relevant rise or fall in troponin
2. Dynamic ST- or T-wave changes (symptomatic or silent)
3. GRACE score >140

Secondary criteria

4. Diabetes mellitus
5. Renal insufficiency (eGFR <60 mL/min/1.73 m²)
6. Reduced LV function (ejection fraction $<40\%$)
7. Early post-infarction angina
8. Recent PCI
9. Prior CABG
10. Intermediate to high GRACE risk score (<http://www.gracescore.org>)

GRACE ACS Risk Model
Global Registry of Acute Coronary Events

At Admission (in-hospital/to 6 months) | At Discharge (to 6 months)

Age: Years
HR: bpm
SBP: mmHg
Creat.: mg/dL
CHF: Killip Class

Cardiac arrest at admission
 ST-segment deviation
 Elevated cardiac enzymes/markers

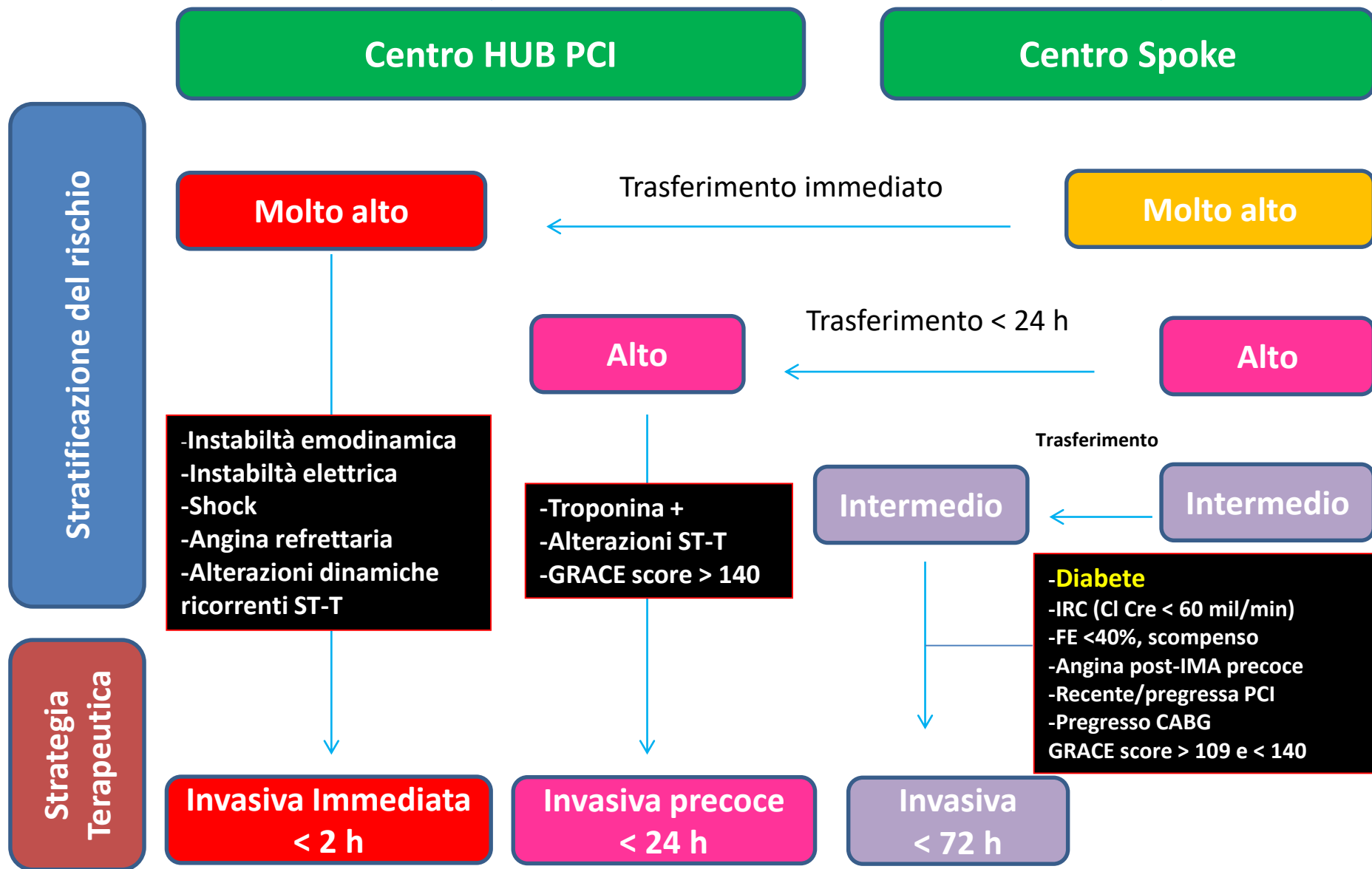
Probability of	Death	Death or MI
In-hospital	--	--
To 6 months	--	--

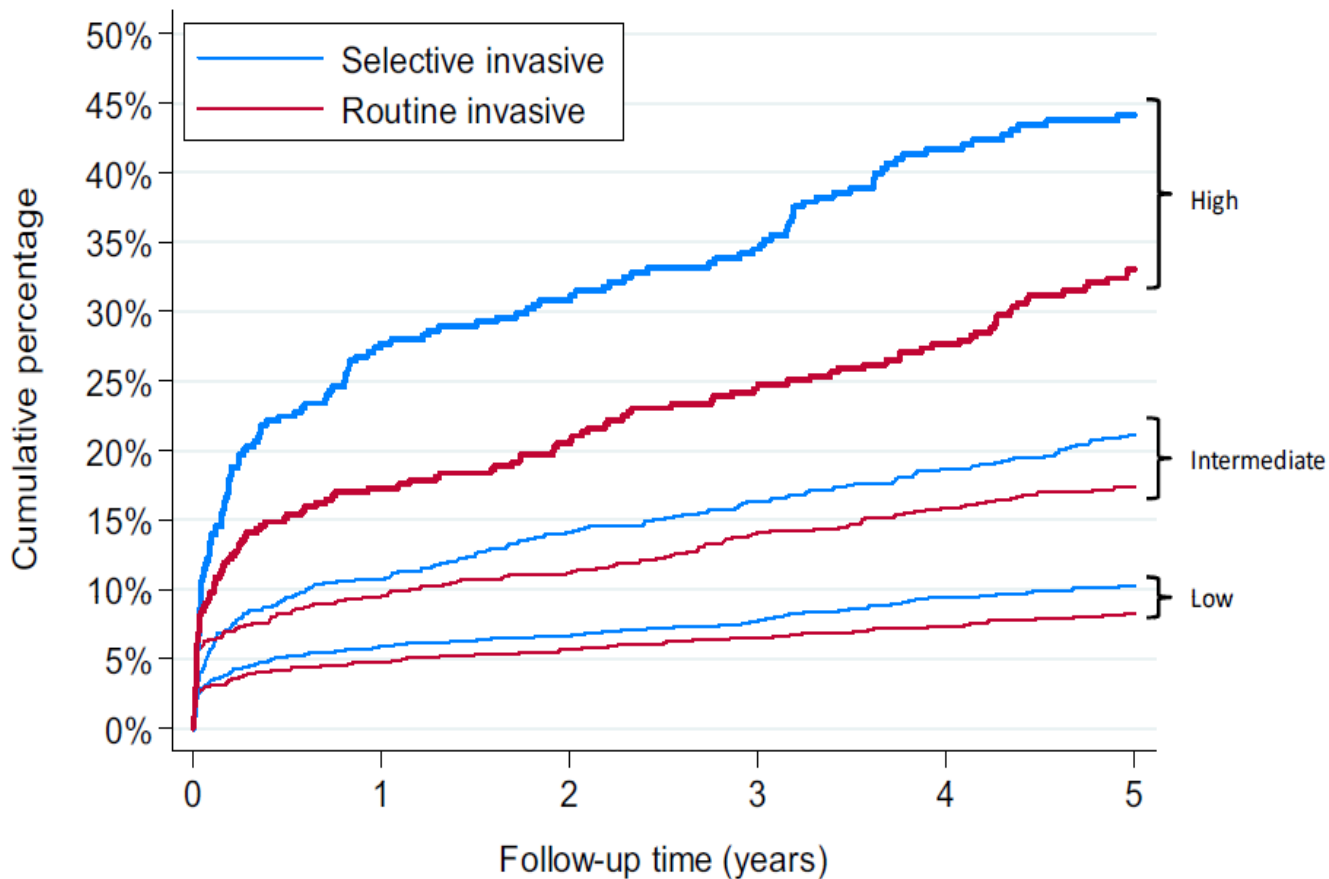
SI Units | Reset | Display Score

Caso clinico

- GRACE di 98, ma diabetico
- Il Tratto ST sottolivellato da V1-V3 e con le acinesie regionali del VS e FE 45%
- Dolore toracico persistente da circa 1 ora + Trop+
- Glicemia 280 mg/dl

Rischio CV Alto





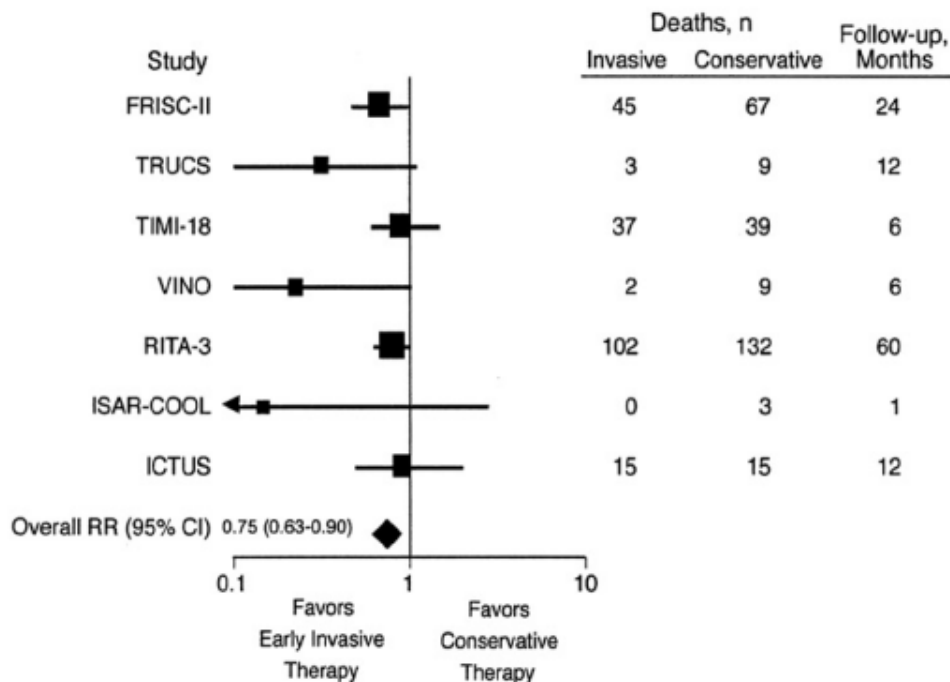
Selective invasive	2746	2452	2351	2178	2077	2005
Routine invasive	2721	2485	2410	2235	2166	2079

Acute Coronary Syndromes

Routine Invasive Versus Conservative Strategy

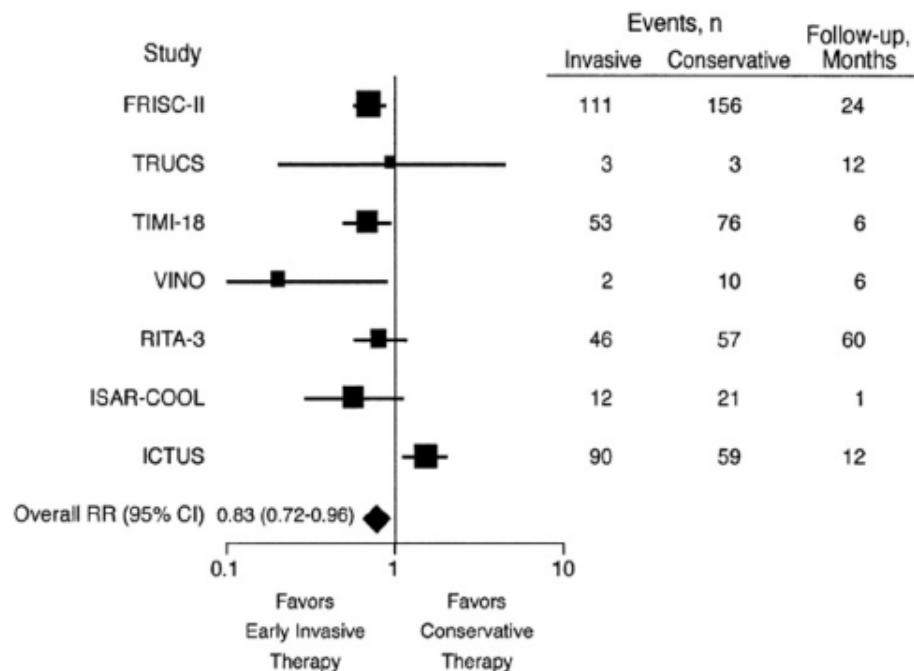
Anderson et al. *J Am Coll Cardiol* 2007;50:e1-157

Death



OR=0.75 (0.63-0.90)

Recurrent MI



OR=0.83 (0.72-0.96)

ACS: Invasive vs. Conservative Strategy

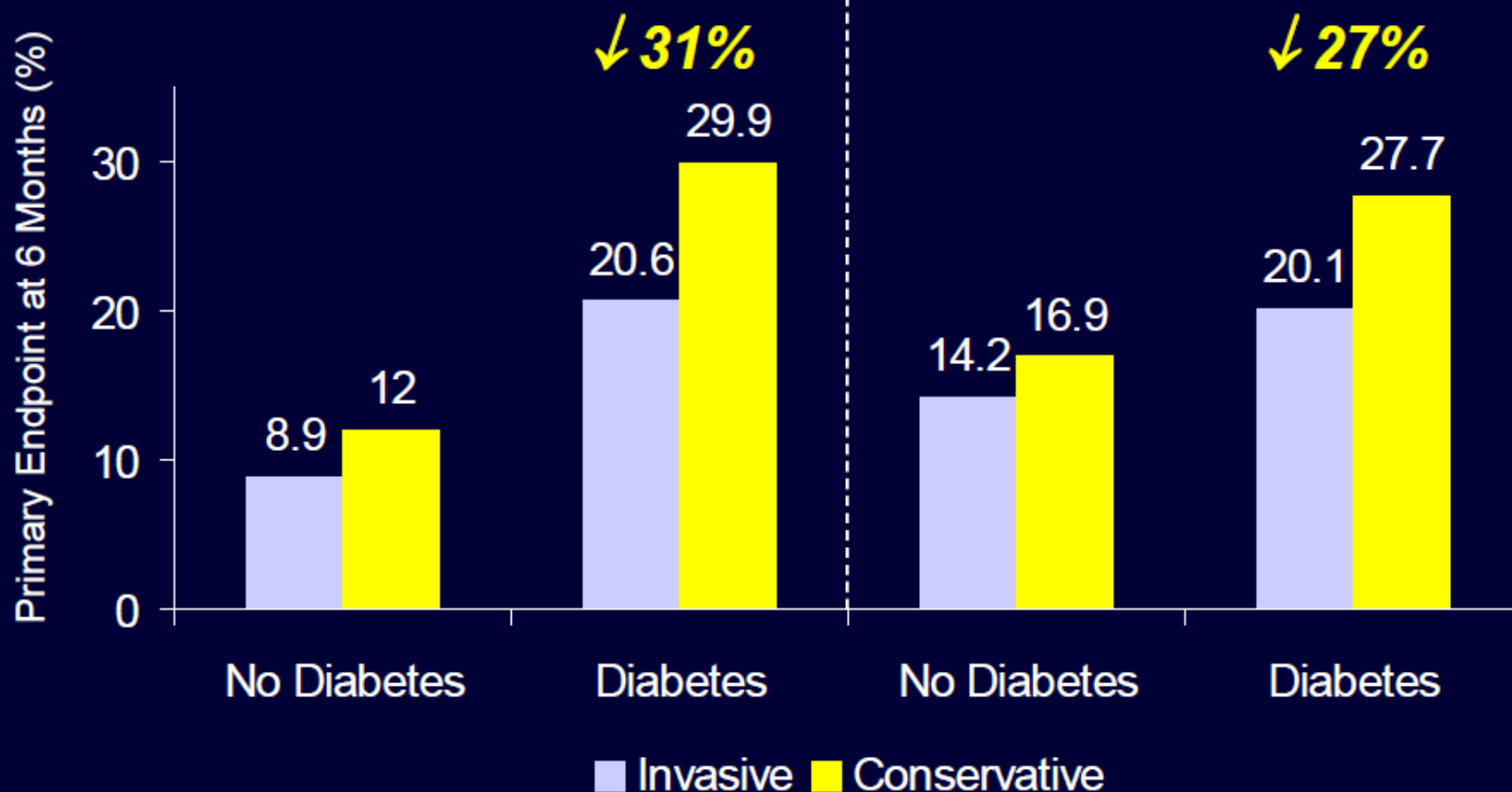
Impact of Diabetes Mellitus

Norhammar A et al. *JACC* 2004;43:585-91

Roffi et al. *Eur Heart J* 2004;25:190-8

FRISC II

TACTICS-TIMI 18

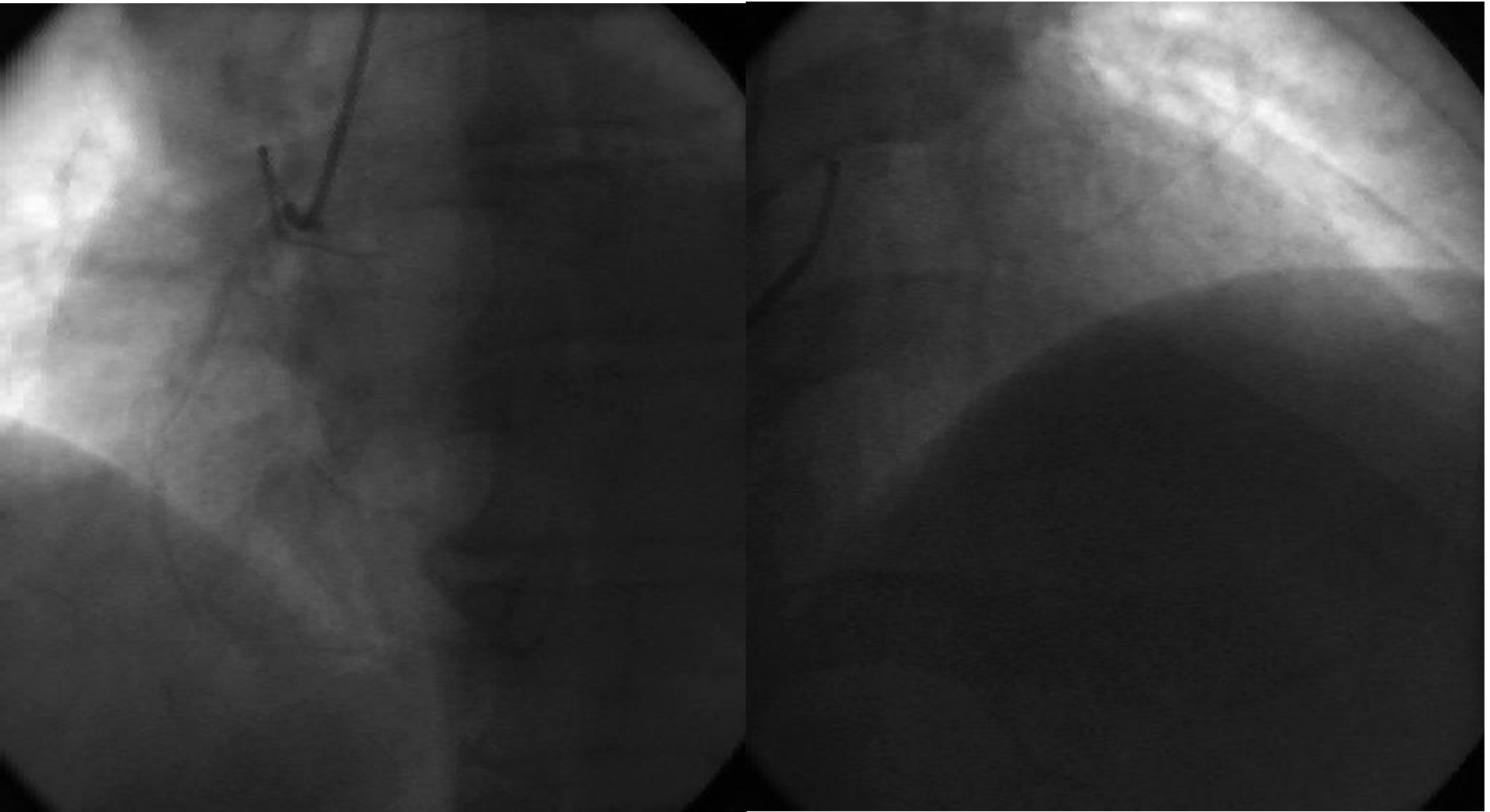


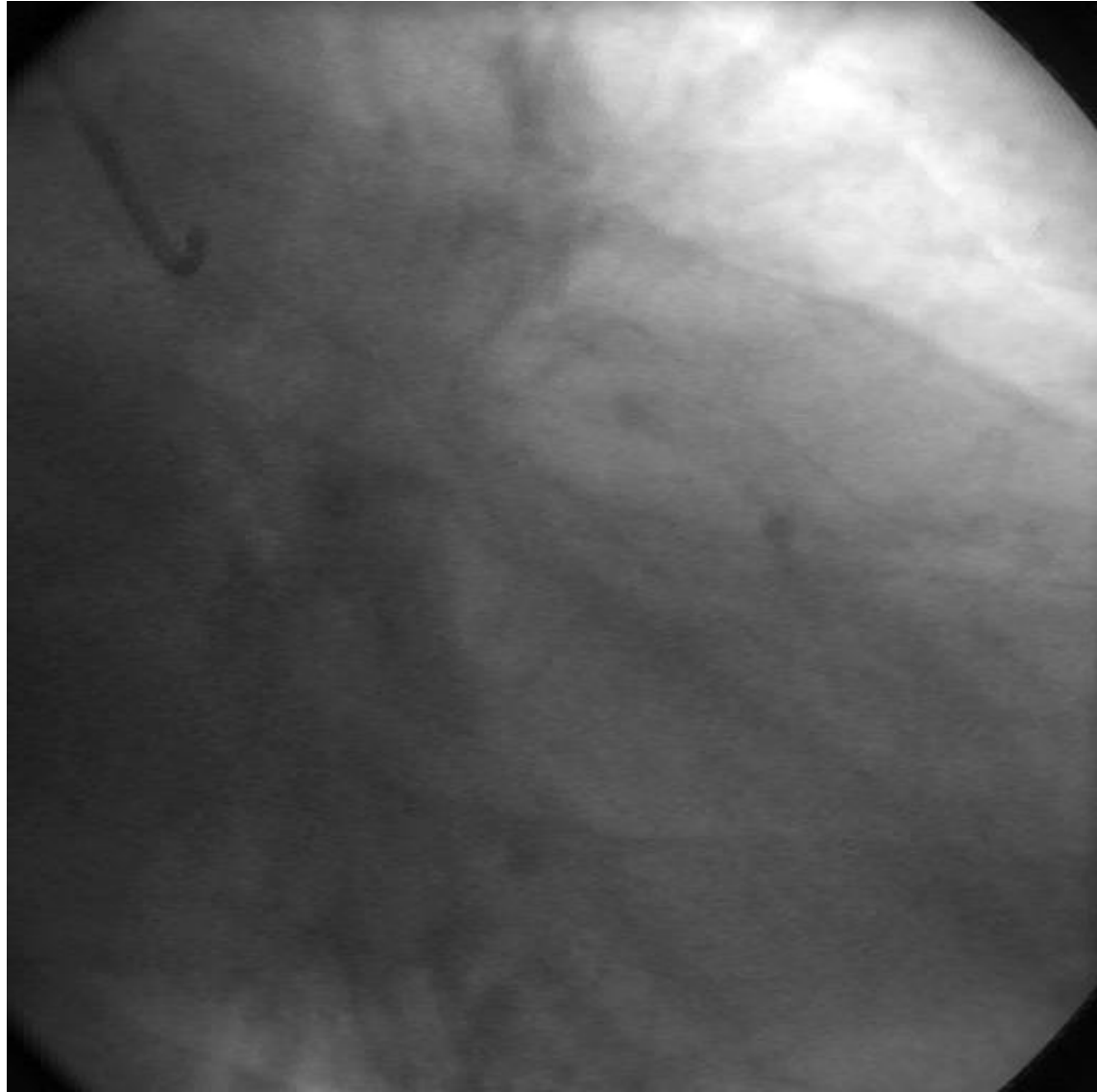
Caso clinico

SNODO DECISIONALE 1: strategia terapeutica

- **Terapia medica ottimale + Clopidogrel 600 mg x os e coronarografia entro 72 ore**
- **Terapia medica ottimale + Ticagrerol 180 mg x os e coronarografia entro 72 ore**
- **Terapia medica ottimale + coronarografia urgente, e trattamento con P2Y12 dopo valutazione anatomia coronarica**

Coronarografia



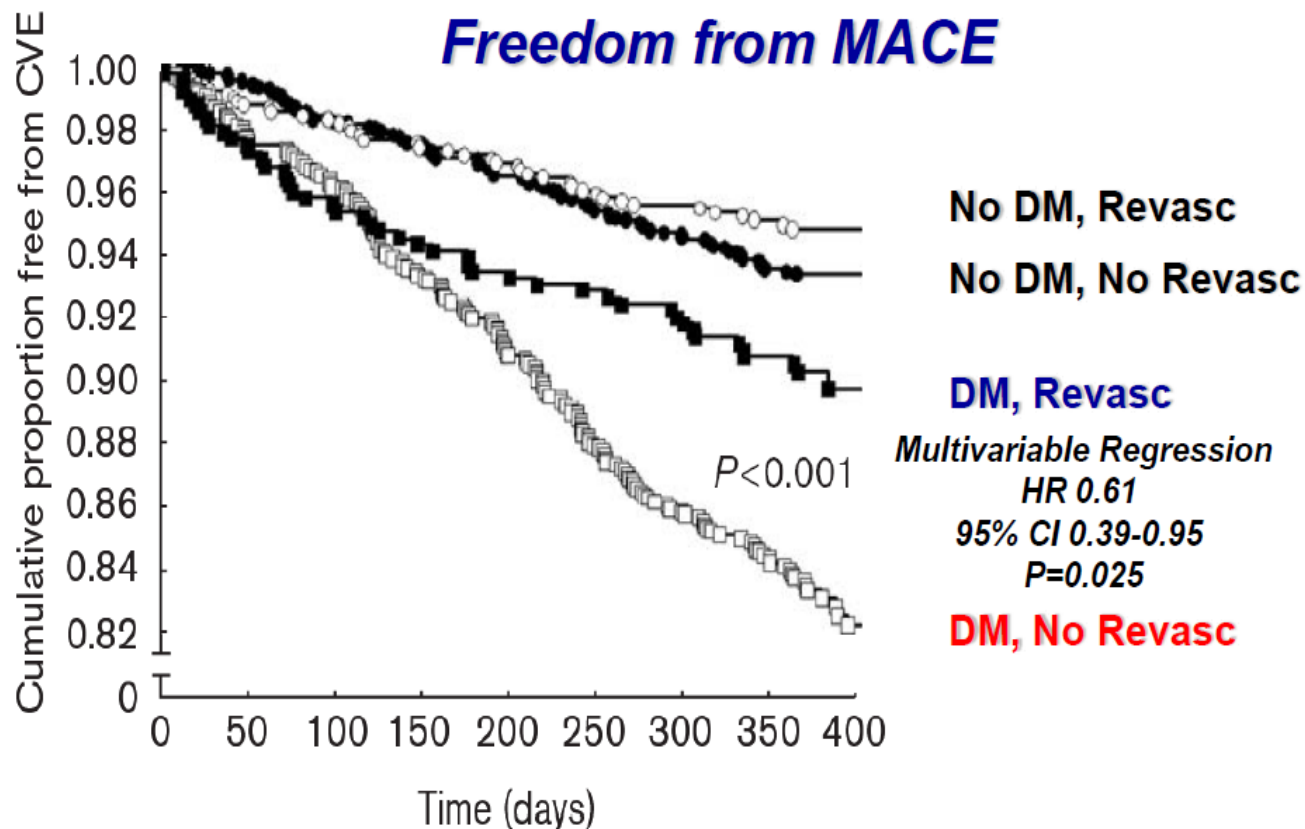


Caso clinico

SNODO DECISIONALE 2: Malattia coronarica di 3 vasi

- Stabilizzazione clinica e Rivascolarizzazione Chirurgica
- PCI della Codx (lesione culprit) e successiva rivascolarizzazione chirurgica di IVA e I MO,
- PCI della Codx e staged IVA e I MO

Diabetes and Revascularization Results from the Euro-Heart Survey

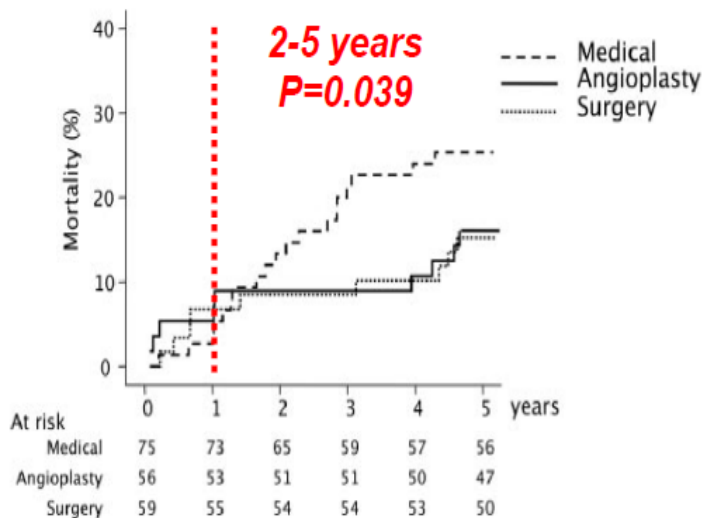


3,488 patients included at 110 centers in 25 European countries

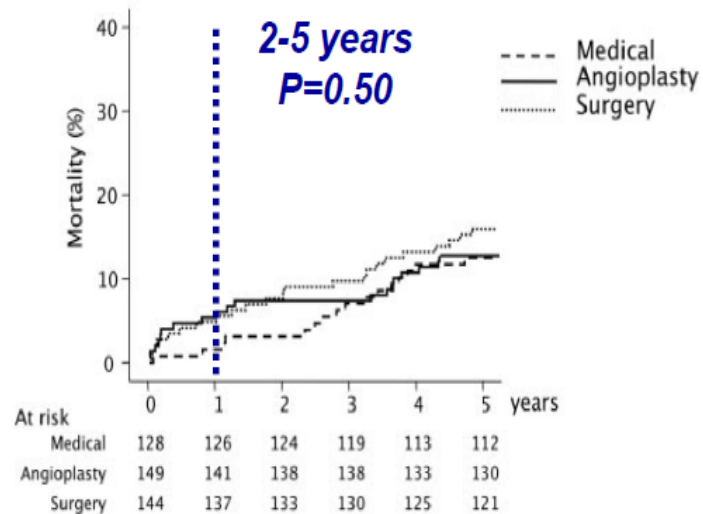
Impact of Revascularization on Mortality in Diabetic Patients With Multivessel Disease

MASS II trial: 611 patients with multivessel disease randomly assigned to medical treatment, PCI or CABG

Diabetic Patients



Non-Diabetic Patients

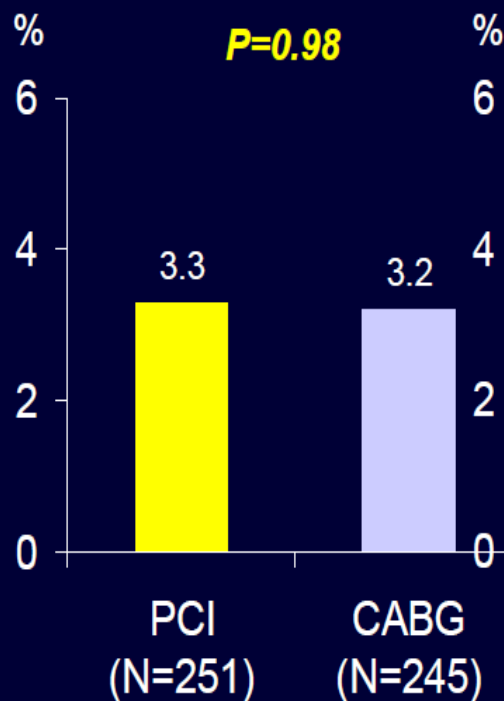


CARDIA – Clinical Outcome @ 12 Months

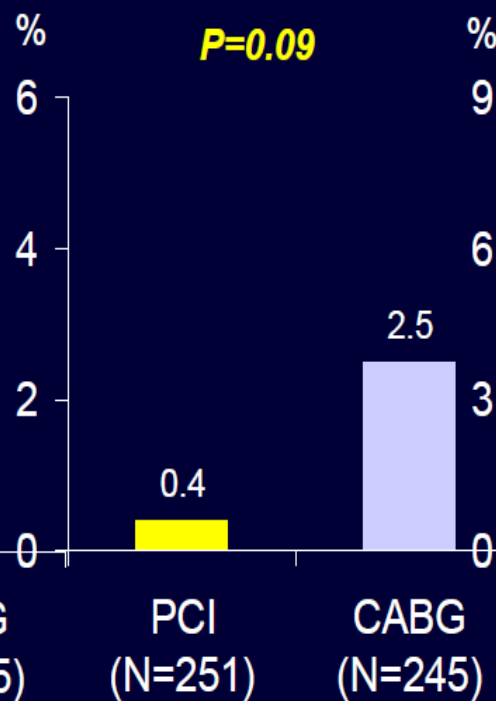
Kapur A et al. *Late Breaking Clinical Trial* ESC 2008

RCT comparing CABG and PCI in diabetic patients

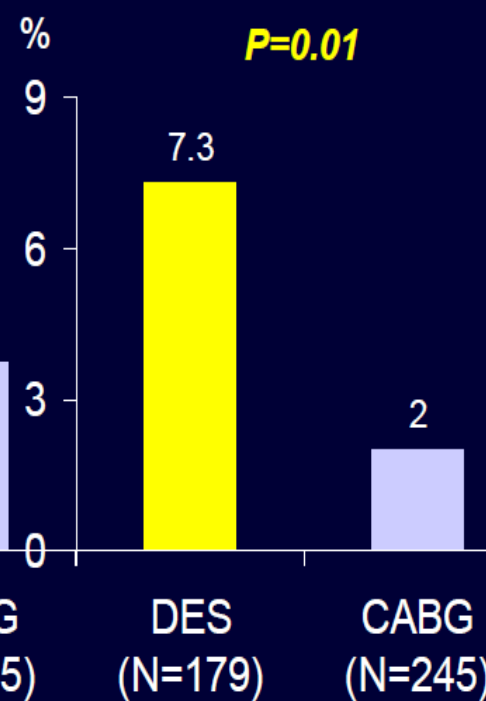
All Cause Death



Stroke



Revascularization



Come stratificare il rischio chirurgico?

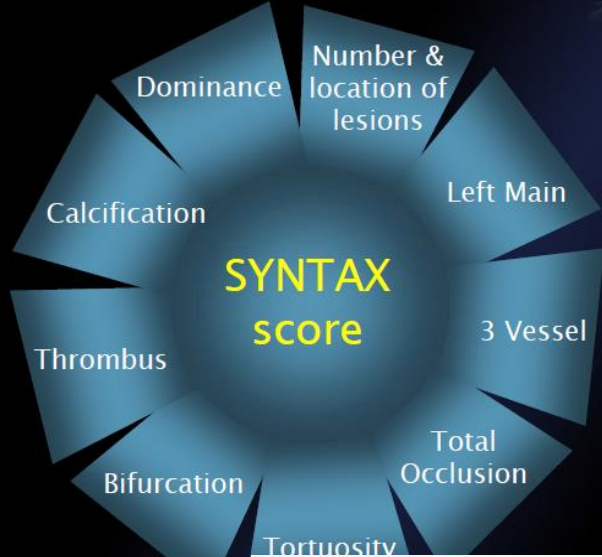
- **Euro score:** score di rischio clinico
- **Syntax score:** score di rischio su estensione anatomica della malattia coronarica

Euro Score > 4 = alto rischio

Important: The previous additive¹ and logistic² EuroSCORE models are out of date. A new model has been prepared from fresh data and is launched at the 2011 EACTS meeting in Lisbon. The model is called EuroSCORE II³ - this online calculator has been updated to use this new model. If you need to calculate the older "additive" or "logistic" EuroSCORE please visit the old calculator by [clicking here](#).

Patient related factors			Cardiac related factors		
Age ¹ (years)	<input type="text" value="0"/>	<input type="text" value="0"/>	NYHA	<input type="text" value="select"/>	<input type="text" value="0"/>
Gender	<input type="text" value="select"/>	<input type="text" value="0"/>	CCS class 4 angina ⁸	<input type="text" value="no"/>	<input type="text" value="0"/>
Renal impairment ² <small>See calculator below for creatinine clearance</small>	<input type="text" value="normal (CC >85ml/min)"/>	<input type="text" value="0"/>	LV function	<input type="text" value="select"/>	<input type="text" value="0"/>
Extracardiac arteriopathy ³	<input type="text" value="no"/>	<input type="text" value="0"/>	Recent MI ⁹	<input type="text" value="no"/>	<input type="text" value="0"/>
Poor mobility ⁴	<input type="text" value="no"/>	<input type="text" value="0"/>	Pulmonary hypertension ¹⁰	<input type="text" value="no"/>	<input type="text" value="0"/>
Previous cardiac surgery	<input type="text" value="no"/>	<input type="text" value="0"/>	Operation related factors		
Chronic lung disease ⁵	<input type="text" value="no"/>	<input type="text" value="0"/>	Urgency ¹¹	<input type="text" value="elective"/>	<input type="text" value="0"/>
Active endocarditis ⁶	<input type="text" value="no"/>	<input type="text" value="0"/>	Weight of the intervention ¹²	<input type="text" value="isolated CABG"/>	<input type="text" value="0"/>
Critical preoperative state ⁷	<input type="text" value="no"/>	<input type="text" value="0"/>	Surgery on thoracic aorta	<input type="text" value="no"/>	<input type="text" value="0"/>
Diabetes on insulin	<input type="text" value="no"/>	<input type="text" value="0"/>			
EuroSCORE II	<input type="text" value="0"/>				
EuroSCORE II					

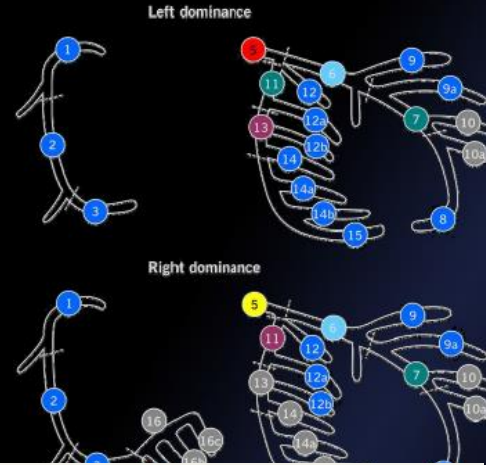
Components of the SYNTAX Score



Lesion Location



Points added based on dominance x location of lesion:



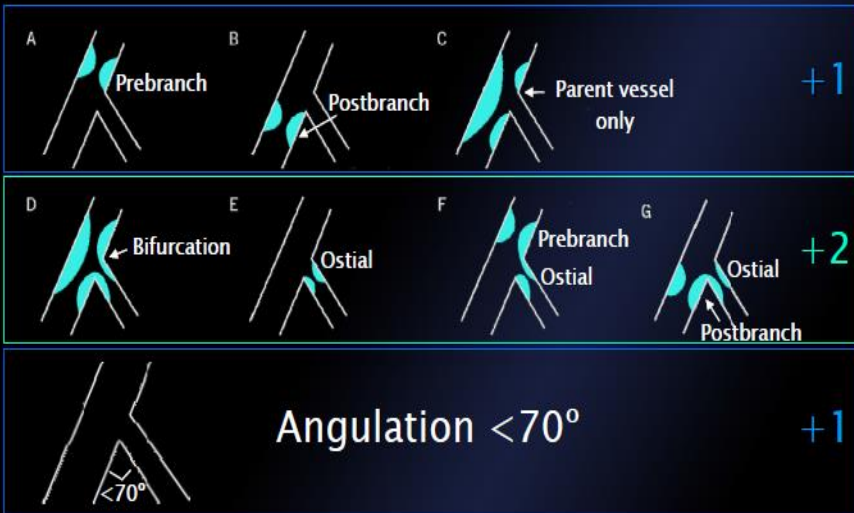
- Points**
- +6
 - +5
 - +3.5
 - +2.5
 - +1.5
 - +1
 - +0.5

SYNTAX score > 32 = alto rischio

Bifurcations

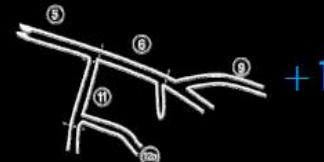


Points added based on type of bifurcation:



Points added based on other adverse lesion characteristics:

Aorto ostial lesion



Severe tortuosity



Lesion Length >20mm



Heavy calcification



Thrombus

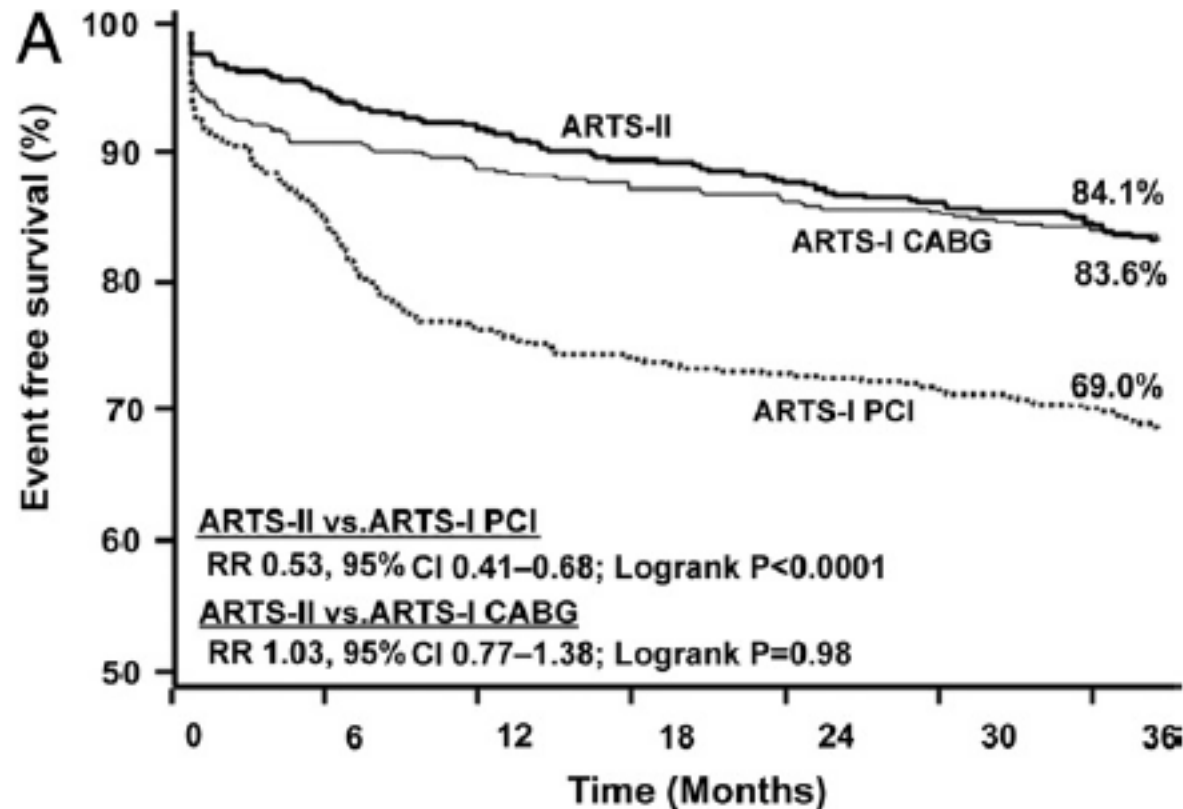


"Diffuse disease" / small vessels

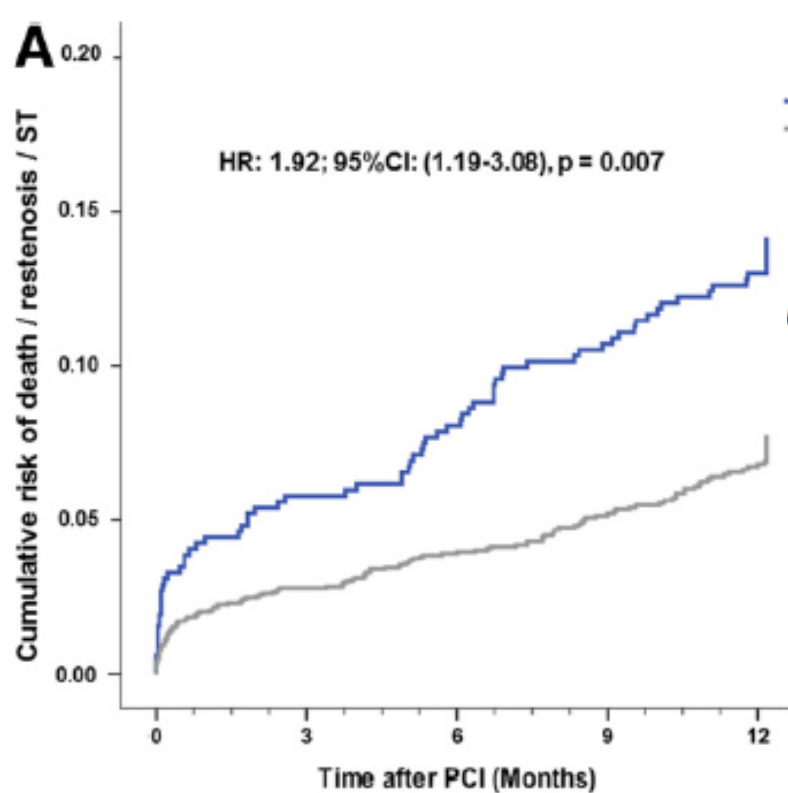


Multivessel Coronary Revascularization in Patients With and Without Diabetes Mellitus

3-Year Follow-Up of the ARTS-II
(Arterial Revascularization Therapies Study-Part II) Trial

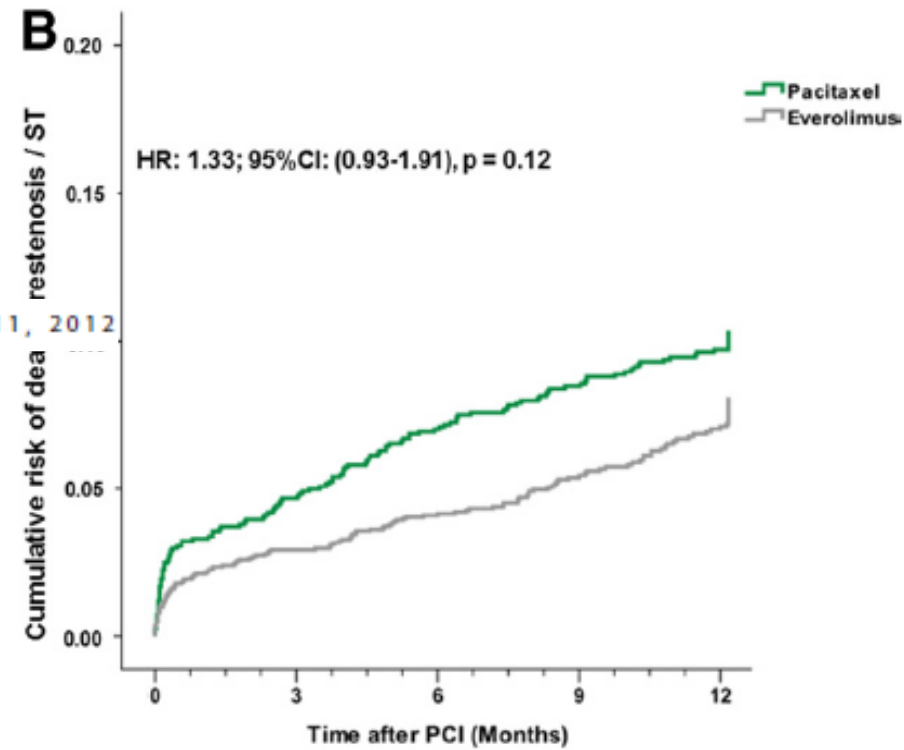


Clinical Impact of Second-Generation Everolimus-Eluting Stent Compared With First-Generation Drug-Eluting Stents in Diabetes Mellitus Patients



Number at risk:

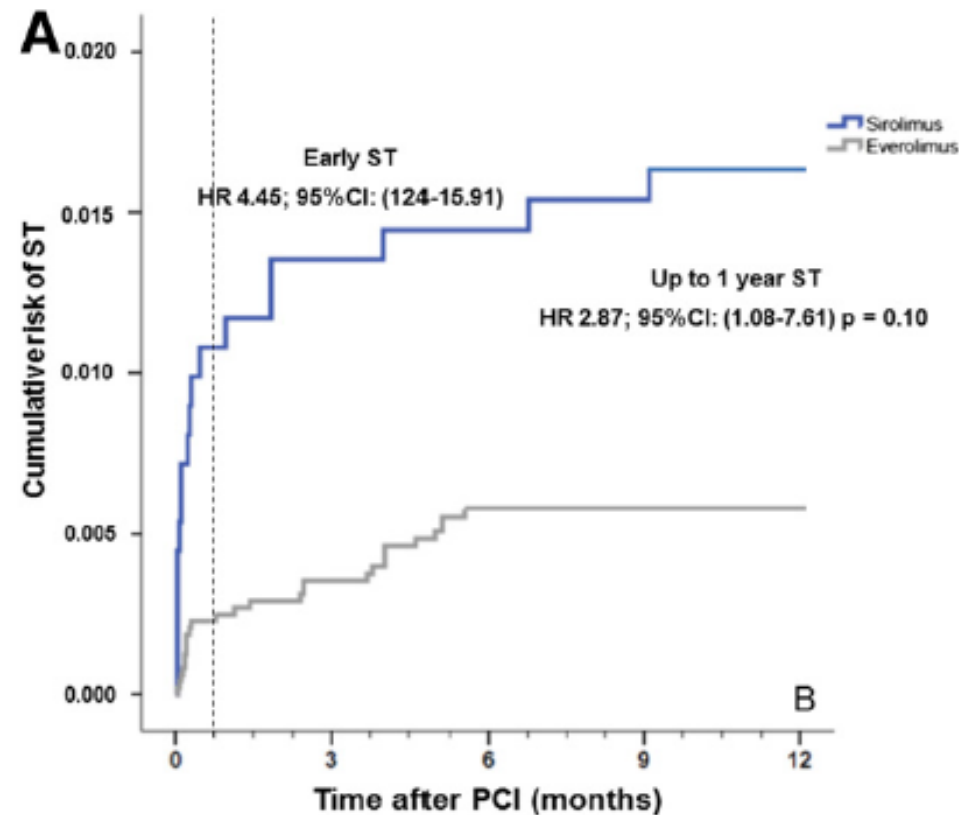
Sirolimus	717	675	633
Everolimus	1915	1552	984



Number at risk:

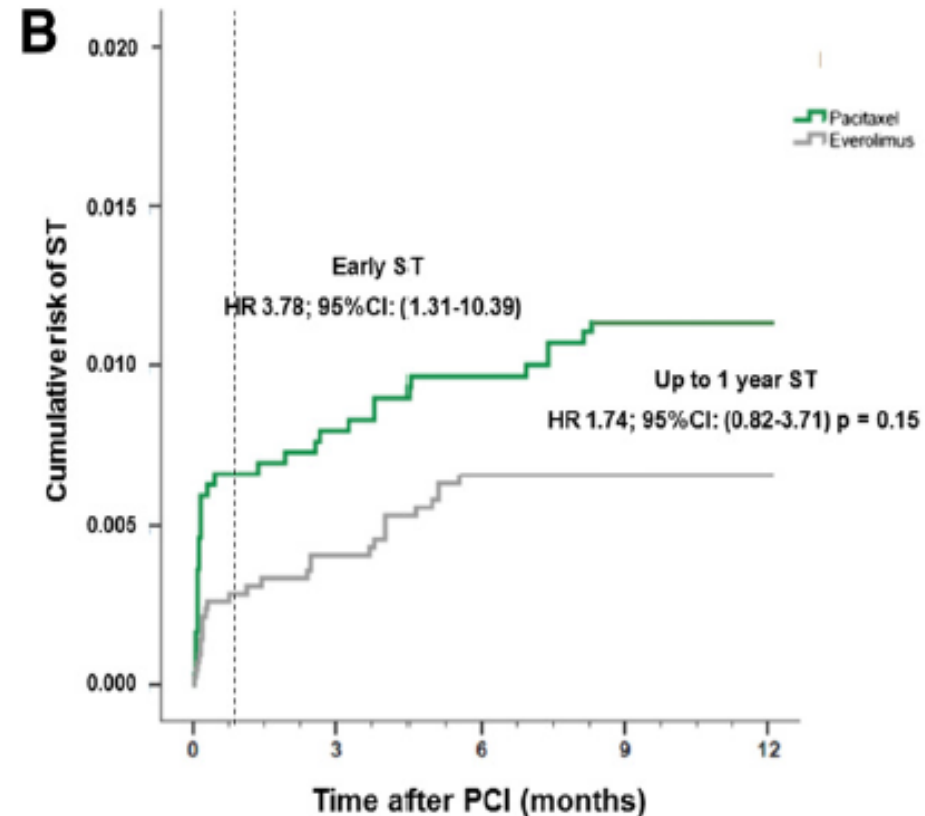
Paclitaxel	1386	1290	1230
Everolimus	1915	1552	984

più sicuri in termini di Stent Thrombosis



Number at risk:

	0	3	6	9	12
Sirolimus	1365	1296	1216		
Everolimus	3912	3198	2012		



Number at risk:

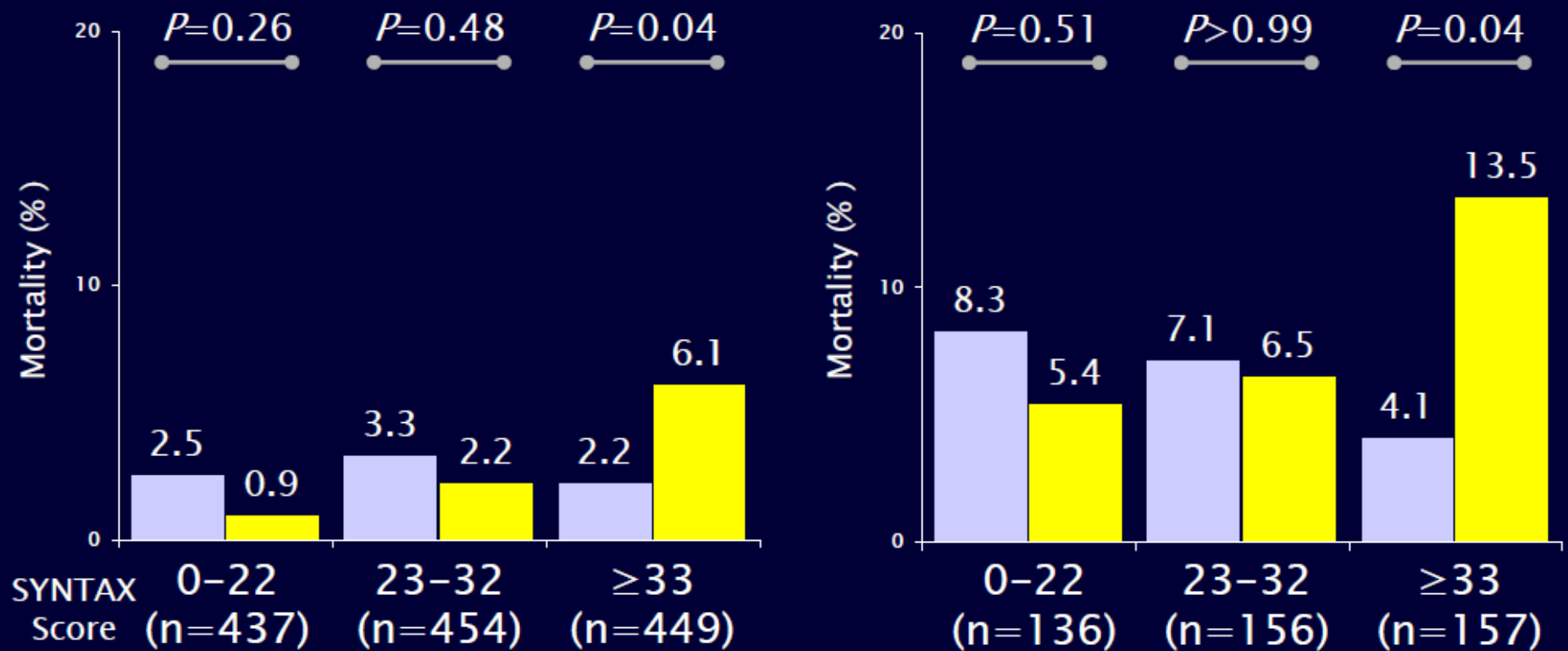
	0	3	6	9	12
Paclitaxel	2828	2641	2514		
Everolimus	3912	3198	2012		

Mortality by SYNTAX Score

■ CABG ■ TAXUS Stent

Non-Diabetic

Diabetic

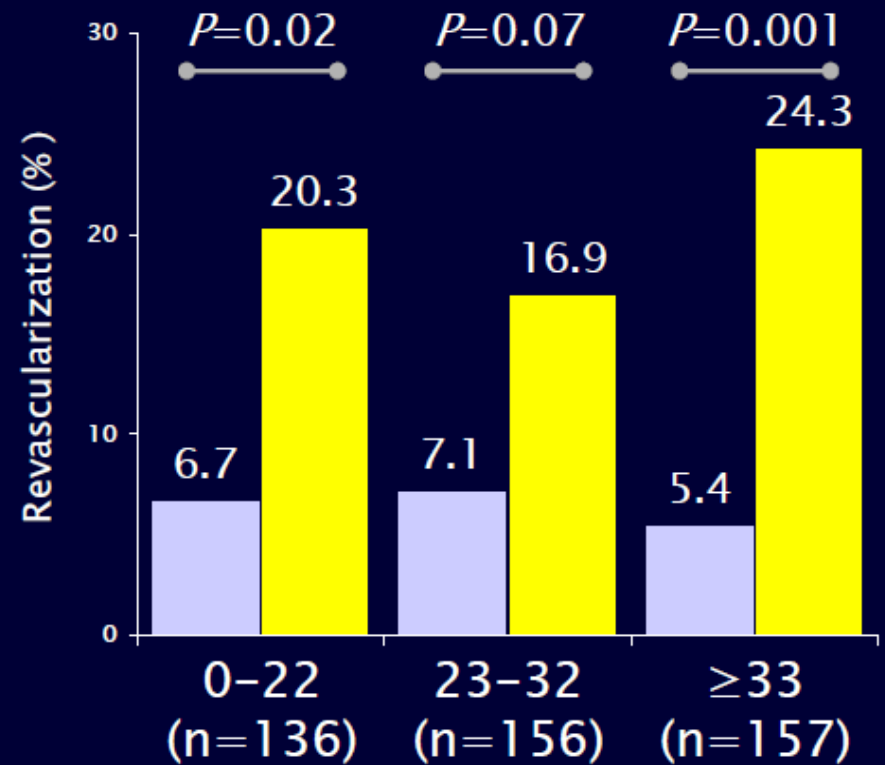
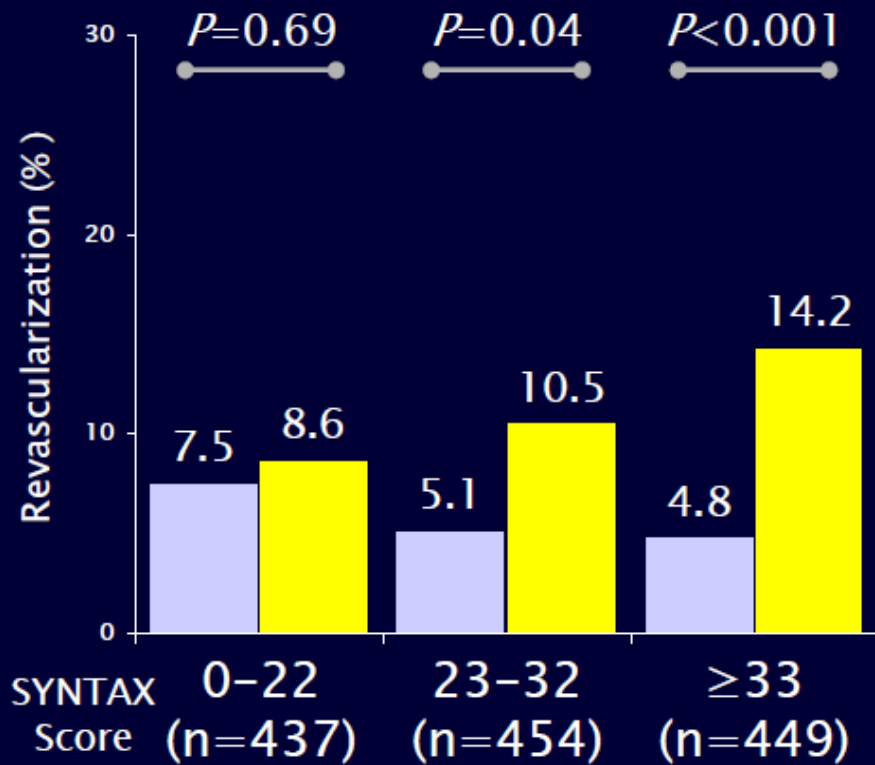


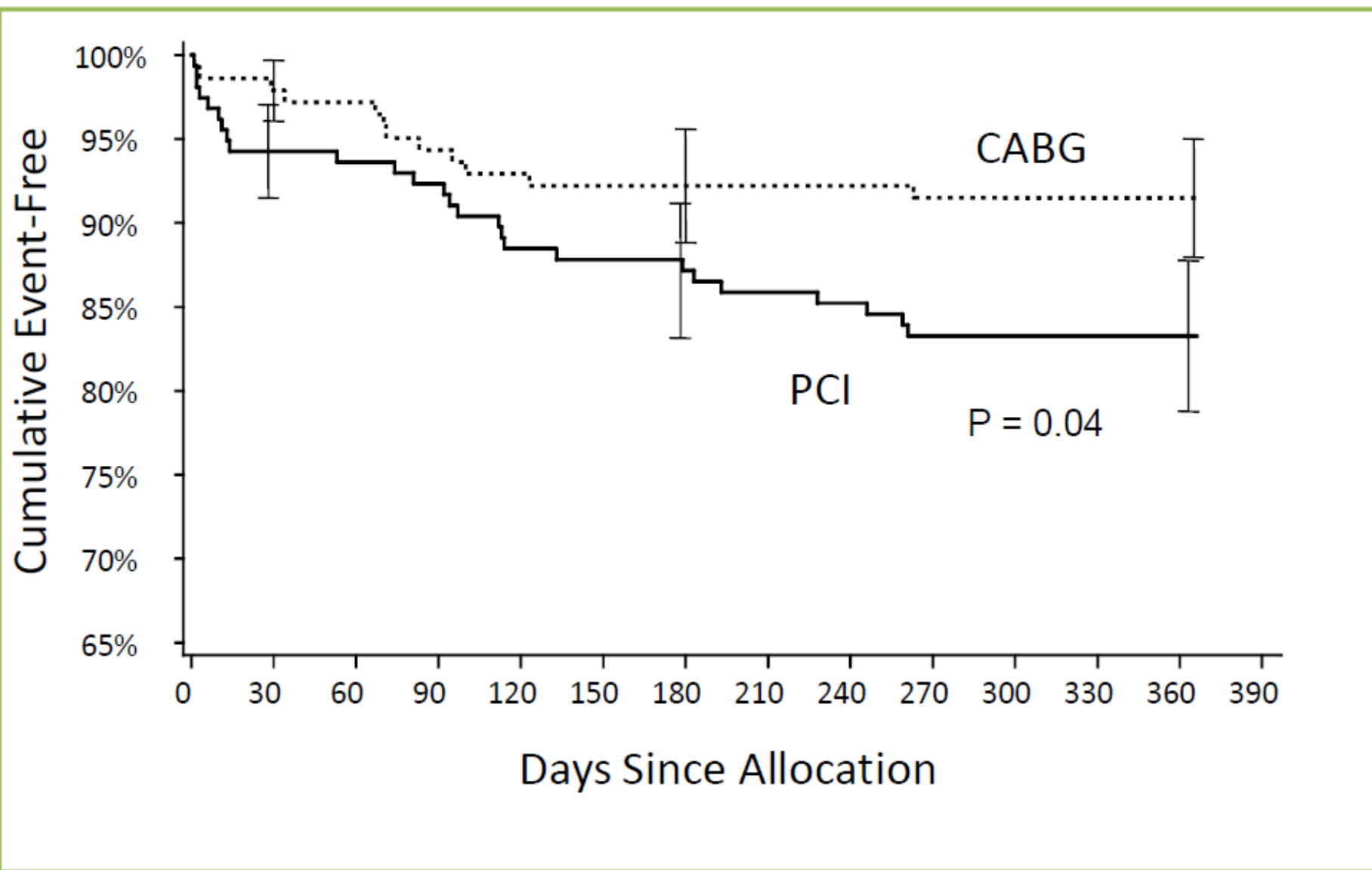
Revascularization by SYNTAX Score

■ CABG ■ TAXUS Stent

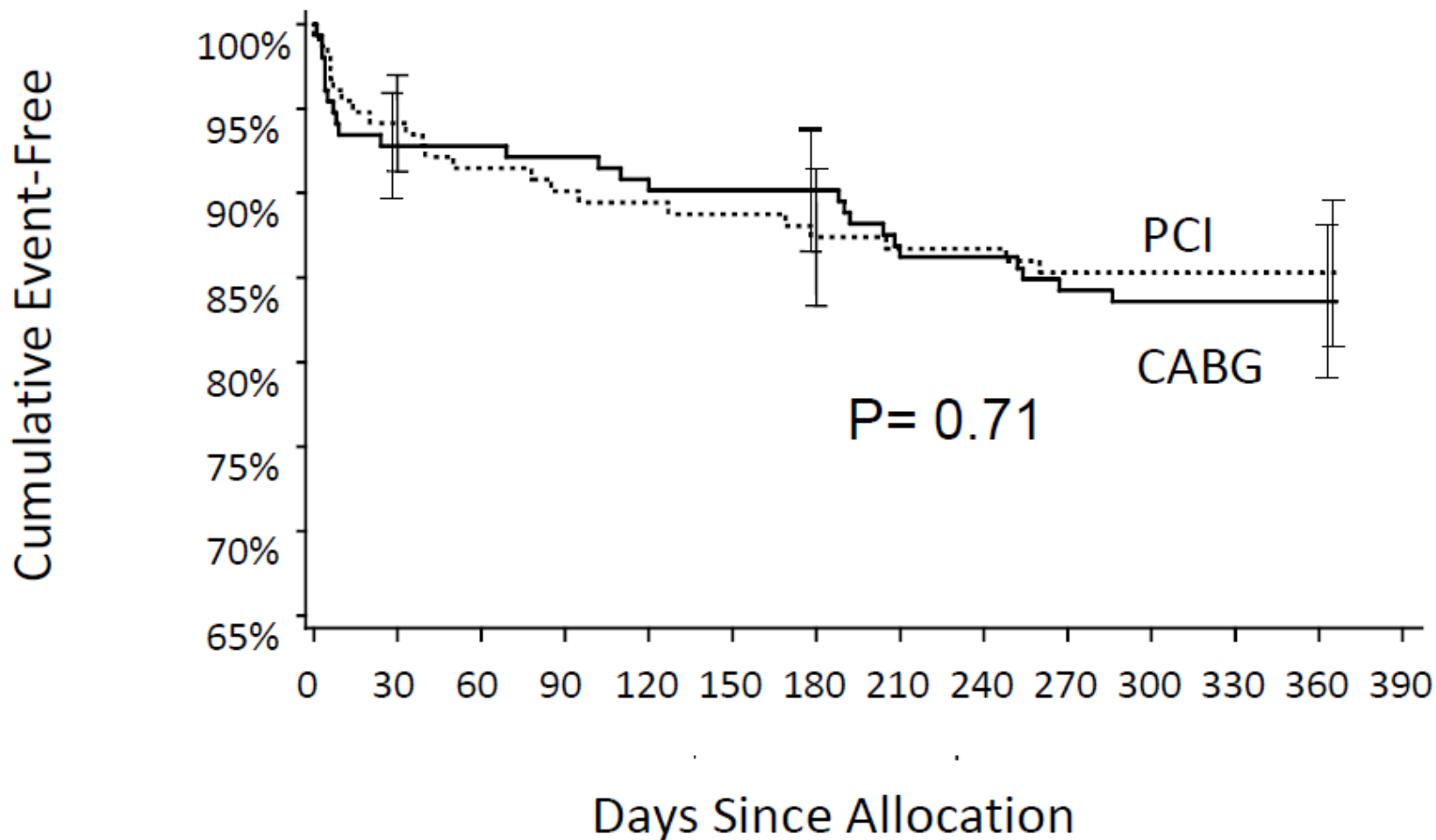
Non-Diabetic

Diabetic





EUROSCORE > 4 and 22 < Syntax Score <= 32



Syntax score stimato per il paziente

Euro Score = 1,54%

(56 anni, uomo, diabete, NYHA I, FE 45%, recente IMA, CABG urgente)

Syntax Score = 11,5

Co Dx: + 2 (lesioni) + 2 (biforcazione) + 1 (lunghezza) = 5

IVA: + 2,5 (lesione) + 2 (biforcazione) + 1 (lunghezza) = 5,5

MO: +1 (lesione) = 1

Algoritmo di rivascularizzazione con coronaropatia multivasale e tronco comune

SYNTAX score	Basso rischio chirurgico	Alto rischio chirurgico
Basso ≤ 22	<i>CABG, PCI</i>	<i>PCI</i>
Intermedio 23-32	<i>CABG, PCI</i>	<u>CABG, PCI</u>
Alto ≥ 33	<i>CABG</i>	<u>CABG, PCI, procedure ibride</u>

In corsivo: prima opzione terapeutica

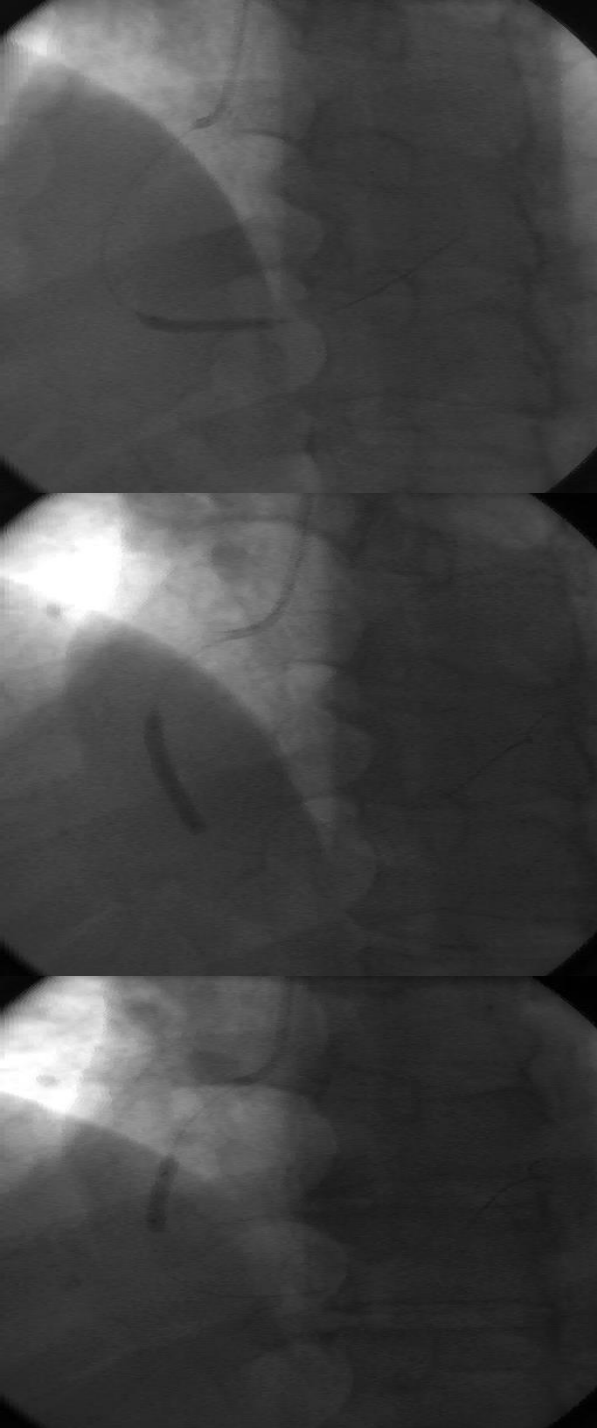
In neretto: opzione terapeutica alternativa

Sottolineato: opzione terapeutica da discutere

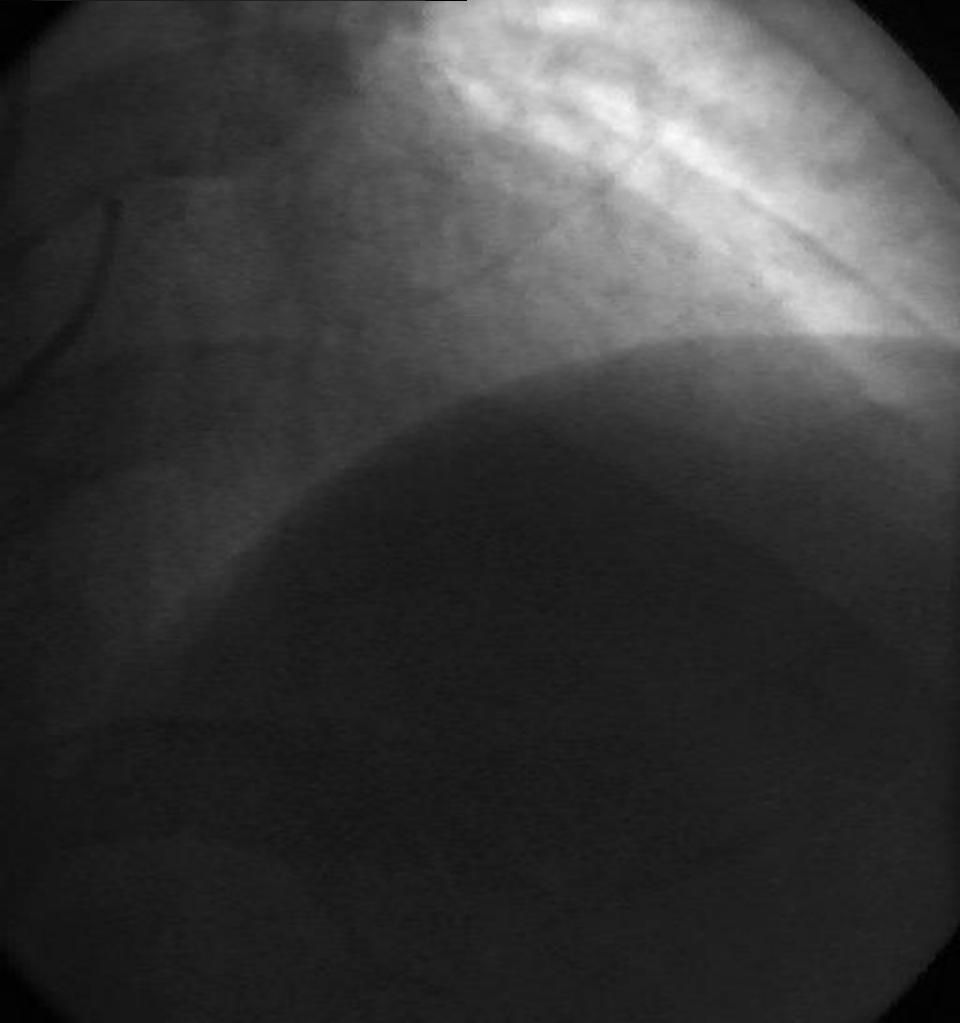
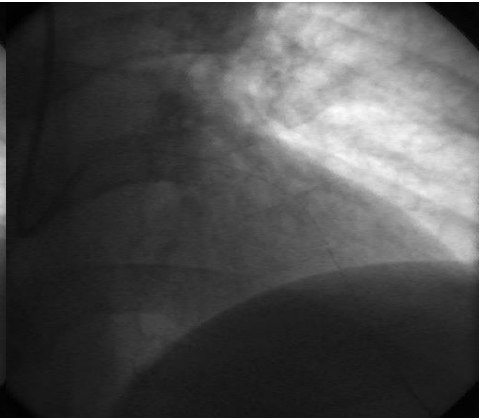
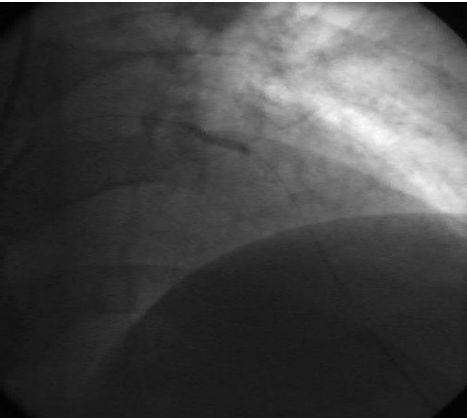
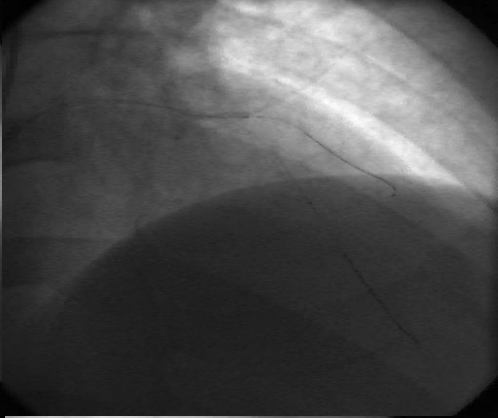
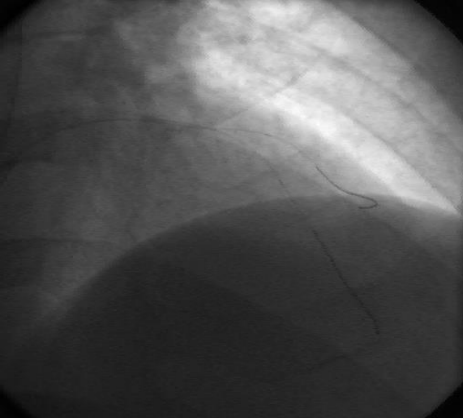
Caso clinico

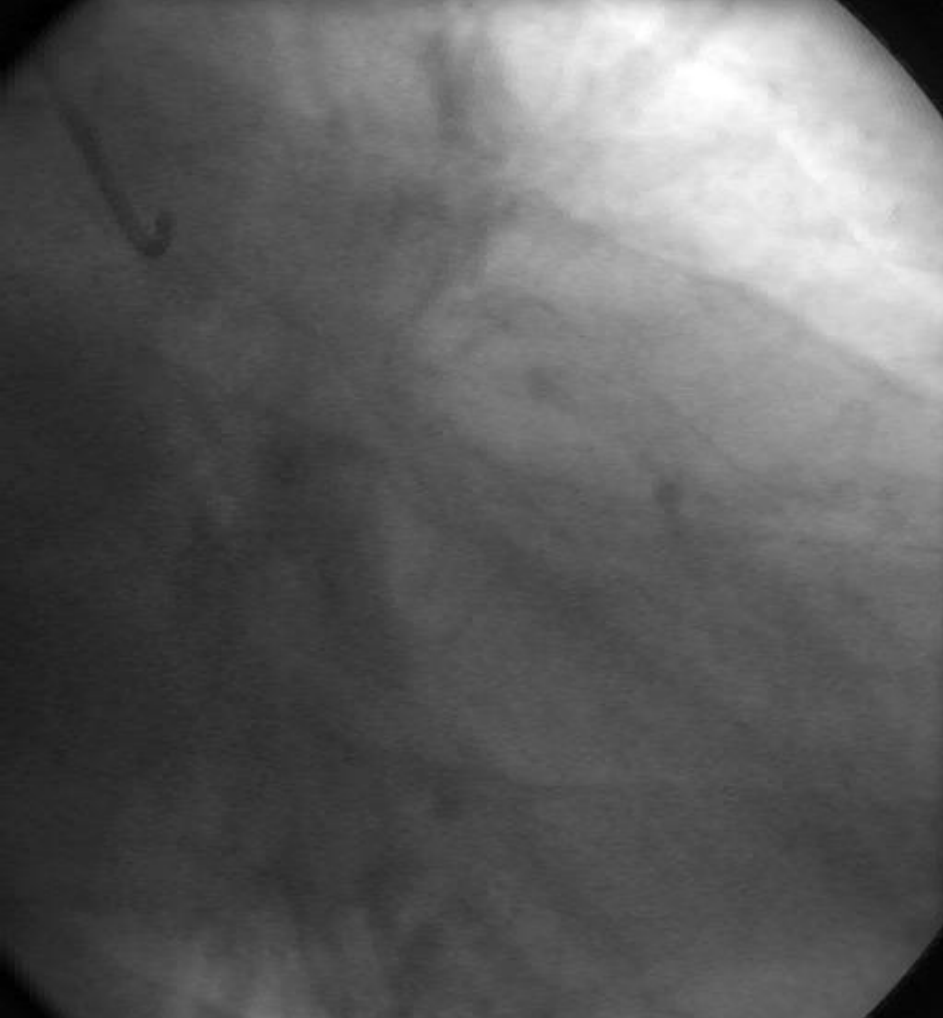
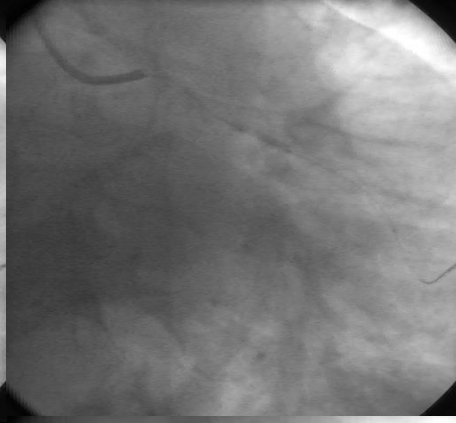
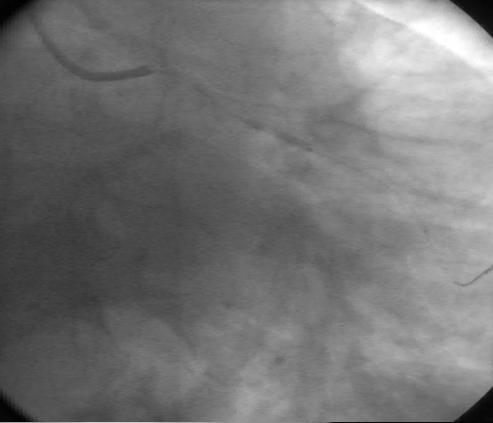
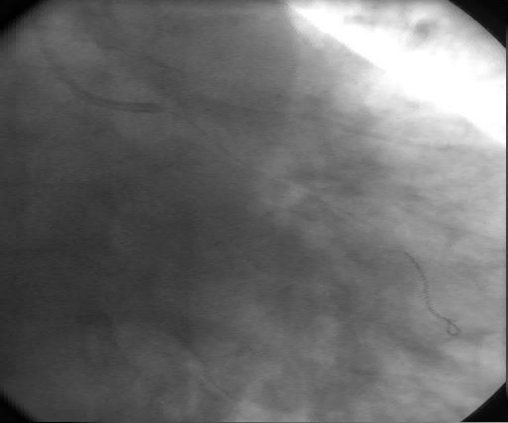
SNODO DECISIONALE 2: Malattia coronarica di 3 vasi

- Rivascolarizzazione Chirurgica
- PCI della Codx (lesione culprit) e successiva rivascolarizzazione chirurgica di IVA e I MO,
- **PCI della Codx e staged IVA e I MO**



3 DES a rilascio di Everolimus
3,5x28 – 3,x28 – 3,5x12 mm





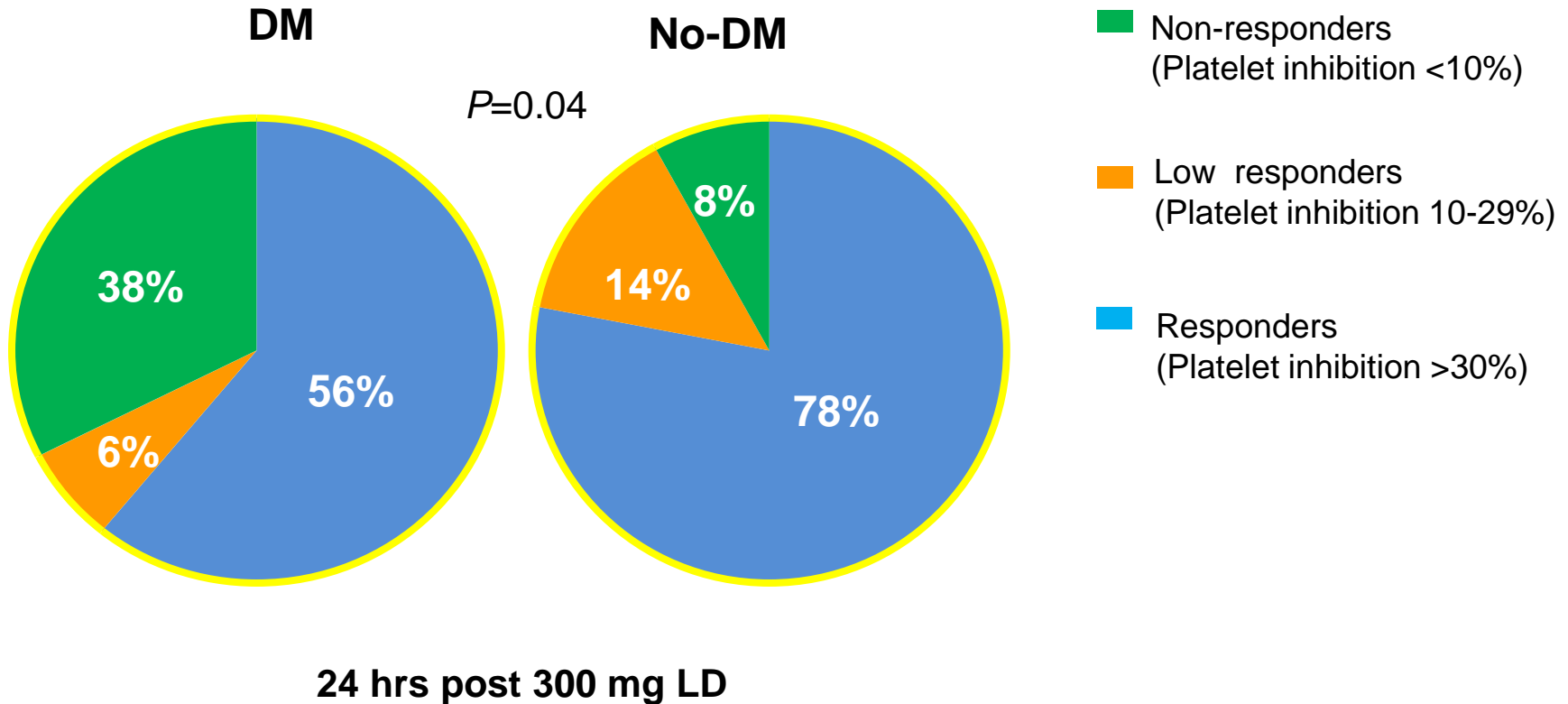
Caso clinico

SNODO DECISIONALE 3: Terapia Antiaggregante

- Clopidogrel 300 mg
- Clopidogrel 600 mg
- Ticagerol 180 mg
- Prasugrel 60 mg

Influence of Diabetes Mellitus on Clopidogrel-induced Antiplatelet Effects

Acute Phase of Treatment



High Residual Platelet Reactivity After Clopidogrel Loading and Long-term Cardiovascular Events Among Patients With Acute Coronary Syndromes Undergoing PCI

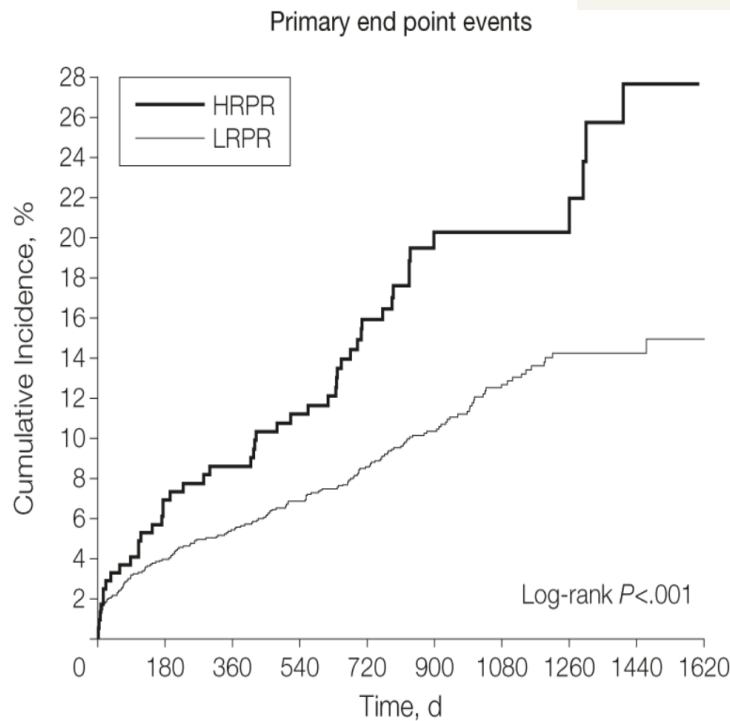
Patients 1789

Aspirin 325 mg + Clopidogrel 600 mg loading dose

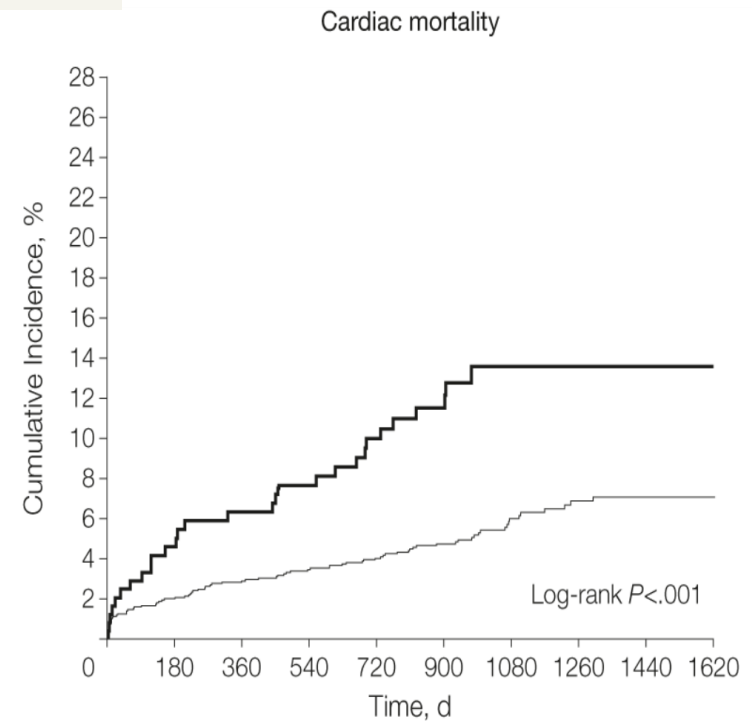
Aspirin 325 mg + Clopidogrel 75 mg die for at least 6 months

Follow-up 2 years

HRPR: incidenza del 14%



No. at risk										
HRPR	247	230	219	213	193	147	80	64	37	10
LRPR	1525	1442	1410	1375	1315	1014	612	451	248	80



No. at risk										
HRPR	247	234	226	221	203	156	84	67	41	12
LRPR	1525	1466	1441	1418	1364	1059	645	476	262	91

High Residual Platelet Reactivity After Clopidogrel Loading and Long-term Cardiovascular Events Among Patients With Acute Coronary Syndromes Undergoing PCI

Table 4. Univariable and Multivariable-Adjusted Predictors of Long-term Primary End Point Events and Cardiac Death

Variables	No. of Events/ No. of Participants ^a	Unadjusted Hazard Ratio (95% CI)	P Value ^b	Multivariable-Adjusted Hazard Ratio (95% CI)	P Value ^b
Primary End Point					
HRPR	49/247	1.82 (1.33-2.50)	<.001	1.49 (1.08-2.05)	.02
Age, mean (SD), per y	74 (11)	1.05 (1.04-1.06)	<.001	1.04 (1.03-1.05)	<.001
Male sex	169/1411	0.76 (0.56-1.03)	.08		
Body mass index $\geq 30^c$	31/292	0.92 (0.63-1.34)	.66		
Smokers	45/431	0.75 (0.54-1.04)	.08		
Diabetes mellitus	57/355	1.38 (1.02-1.86)	.04		
Hypertension	129/1015	1.01 (0.78-1.32)	.92		
Hypercholesterolemia	97/792	0.94 (0.72-1.23)	.66		
Family history of coronary disease	11/121	0.66 (0.36-1.22)	.18		
History of myocardial infarction	67/322	2.02 (1.51-2.68)	<.001	1.50 (1.12-2.02)	.007
Creatinine >1.5 mg/dL	38/185	1.77 (1.25-2.50)	.003	1.52 (1.07-2.17)	.02
LVEF <40%	114/548	2.52 (1.94-3.27)	<.001	1.67 (1.25-2.23)	.001
Killip class III-IV on admission	32/103	3.41 (2.34-4.96)	<.001	2.43 (1.62-3.64)	<.001
3-Vessel coronary disease	86/486	1.72 (1.31-2.25)	<.001		
Use of abciximab	162/1218	1.24 (0.93-1.67)	.15		
Use of drug-eluting stents	127/913	1.04 (0.80-1.36)	.76		
Total stent length, mean (SD), mm	38 (30)	1.01 (1.01-1.02)	.004		
Multivessel PCI	90/549	1.50 (1.15-1.96)	.003		
Cardiac Death					
HRPR	29/247	2.24 (1.47-3.42)	<.001	1.81 (1.18-2.76)	.006
Age, mean (SD), per y	77 (10)	1.08 (1.06-1.10)	<.001	1.06 (1.04-1.08)	<.001
Male sex	85/1411	0.76 (0.49-1.17)	.21		
Body mass index $\geq 30^c$	10/292	0.54 (0.28-1.04)	.07		
Smokers	20/431	0.65 (0.40-1.05)	.08		
Diabetes mellitus	37/355	1.99 (1.34-2.95)	.001		
Hypertension	75/1015	1.49 (1.01-2.20)	.045		
Hypercholesterolemia	54/792	1.14 (0.79-1.65)	.49		
Family history of coronary disease	6/121	0.74 (0.32-1.67)	.47		
History of myocardial infarction	35/322	2.08 (1.40-3.10)	<.001		
Creatinine >1.5 mg/dL	26/185	2.57 (1.66-3.98)	<.001	1.91 (1.22-2.99)	.005
LVEF <40%	69/548	3.76 (2.57-5.48)	<.001	2.16 (1.43-3.26)	<.001
Killip class III-IV on admission	21/103	4.50 (2.80-7.23)	<.001	2.72 (1.63-4.52)	<.001
3-Vessel coronary disease	55/486	2.59 (1.79-3.75)	<.001	1.74 (1.19-2.54)	.004
Use of abciximab	83/1218	1.30 (0.86-1.98)	.22		
Use of drug-eluting stents	66/913	1.15 (0.79-1.68)	.46		
Total stent length, mean (SD), mm	39 (31)	1.01 (1.01-1.02)	.01		
Multivessel PCI	55/549	2.13 (1.47-3.08)	<.001		

Abbreviations: HRPR, high residual platelet reactivity; LVEF, left ventricular ejection fraction; PCI, percutaneous coronary intervention.
^aContinuous variables are presented as mean (SD) in patients who had a primary end point event or cardiac death.
^bBy Cox proportional hazards model.
^cCalculated as weight in kilograms divided by height in meters squared.

Table 3. Two-Year Clinical Outcomes

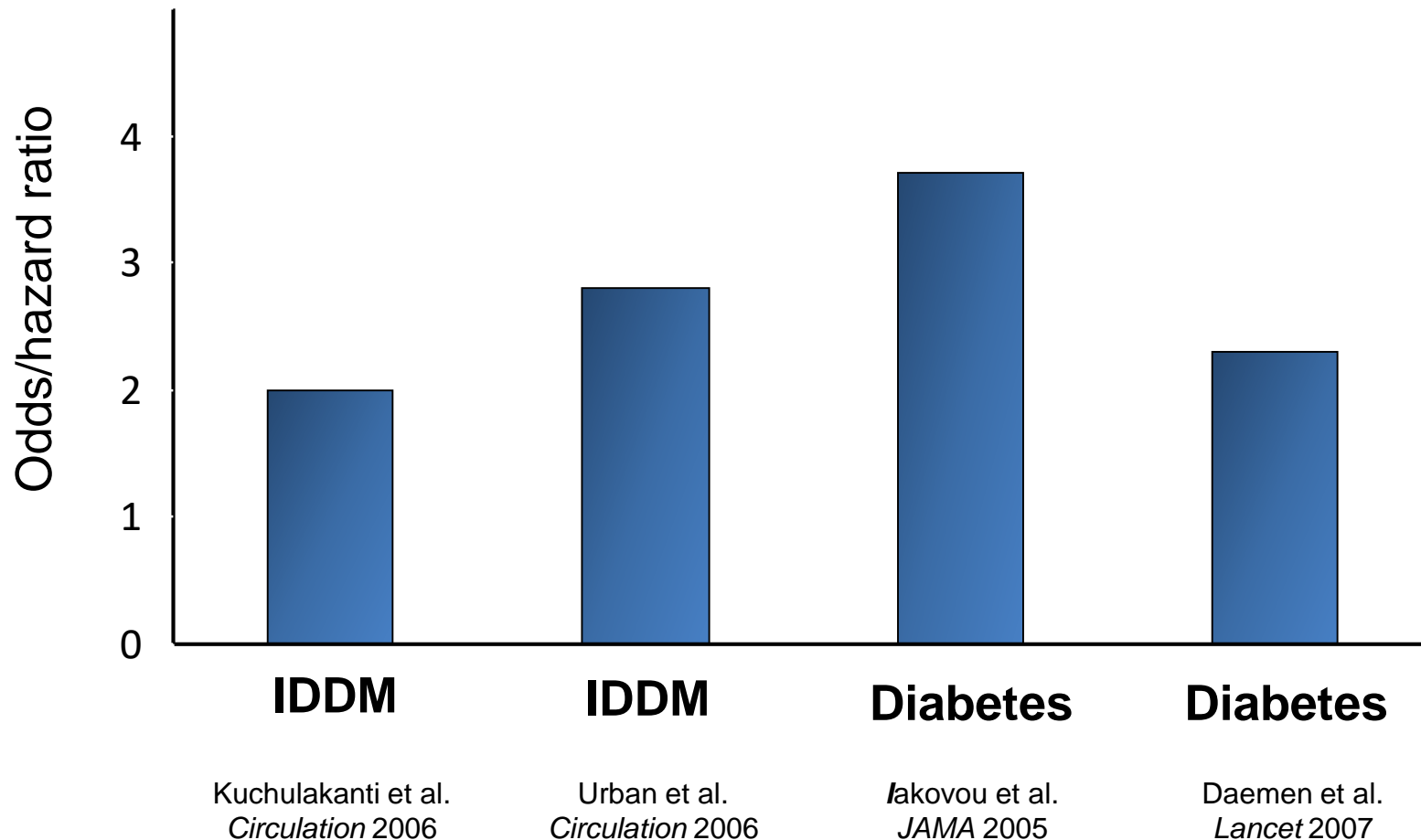
Outcomes	No. (%) of Participants			P Value ^a
	Total (n = 1772)	LRPR (n = 1525)	HRPR (n = 247)	
Primary end point	168 (9.5)	132 (8.7)	36 (14.6)	.003
Cardiac death	89 (5)	65 (4.3)	24 (9.7)	<.001
Myocardial infarction	41 (2.3)	33 (2.2)	8 (3.2)	.30
Urgent coronary revascularization	16 (0.9)	15 (1.0)	1 (0.4)	.71 ^b
Stroke	22 (1.2)	19 (1.2)	3 (1.2)	>.99 ^b
Stent thrombosis	59 (3.3)	44 (2.9)	15 (6.1)	.01
Definite	30 (1.7)	23 (1.5)	7 (2.8)	.13
Probable	15 (0.8)	11 (0.7)	4 (1.6)	.15
Possible	14 (0.9)	10 (0.7)	4 (1.6)	.11

Abbreviations: HRPR, high residual platelet reactivity; LRPR, low residual platelet reactivity.
^aThe χ^2 test was used for comparison unless otherwise indicated.
^bBy Fisher exact test.

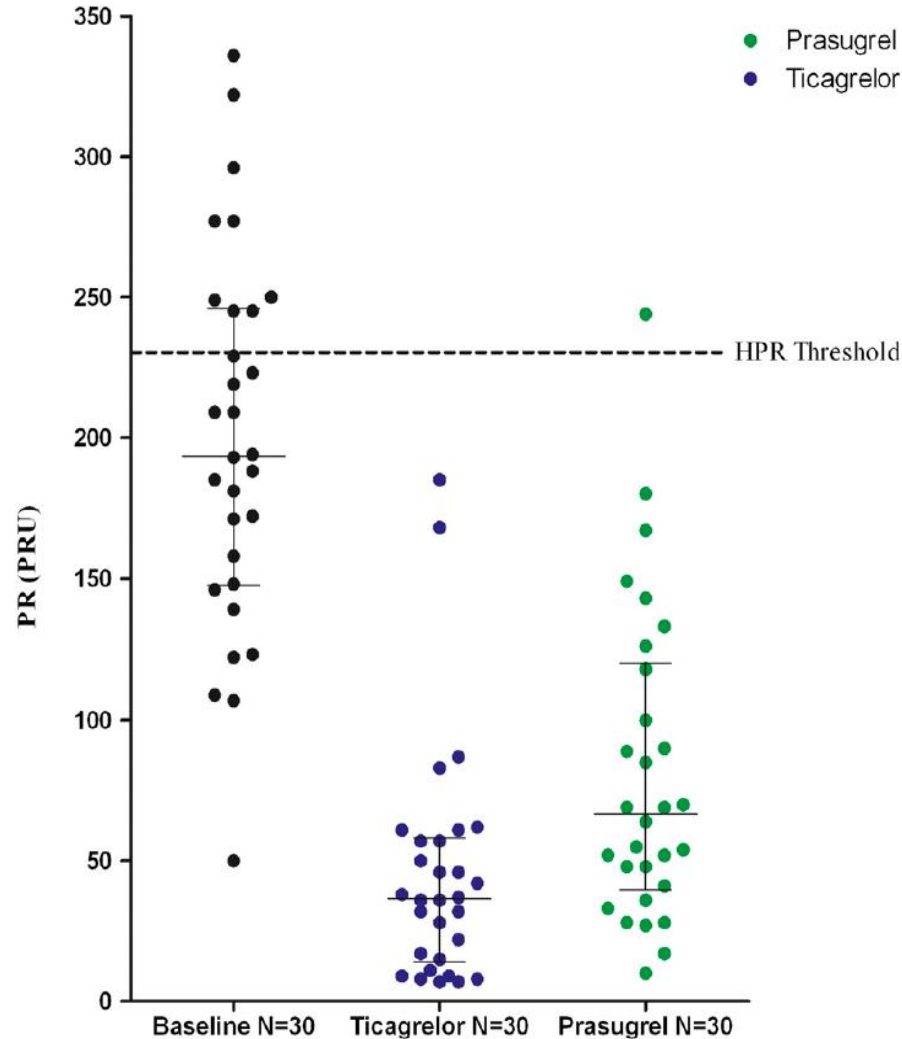
**Stent Thrombosis 6,1% HRPR
2,9% LRPR**

Absolute Increase Risk 3,2%

Diabetes as Predictor of Stent Thrombosis at 1 Year in the Era of DES

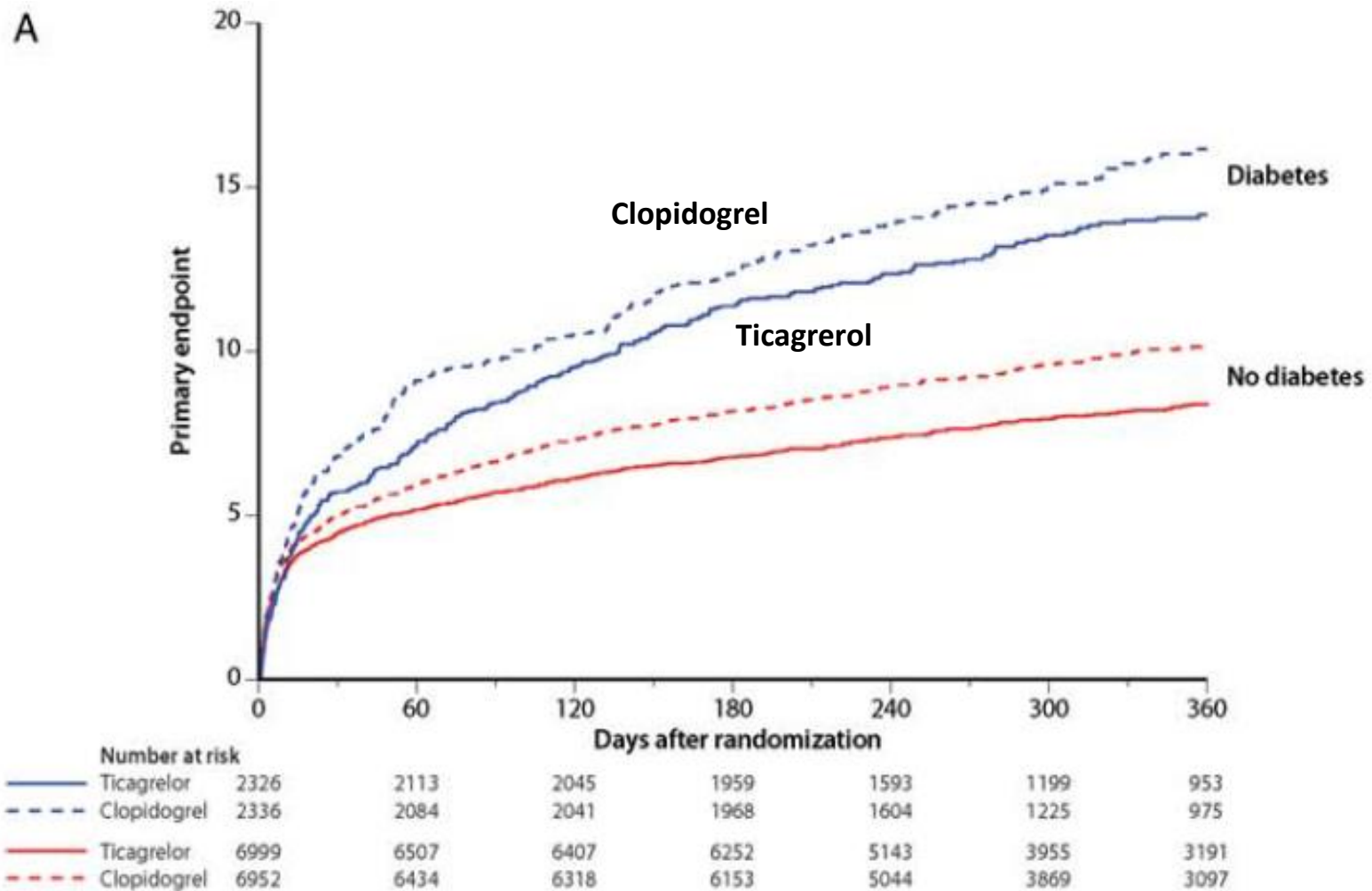


Randomized Assessment of Ticagrelor Versus Prasugrel Antiplatelet Effects in Patients With Diabetes



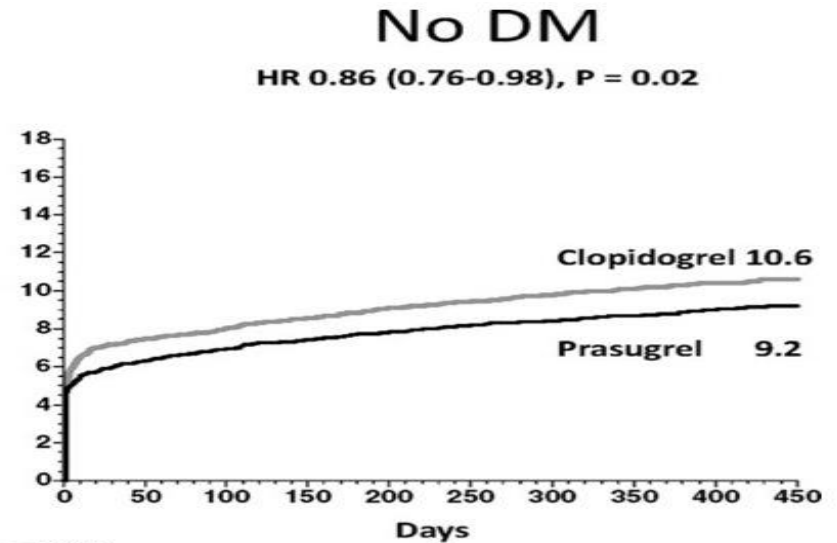
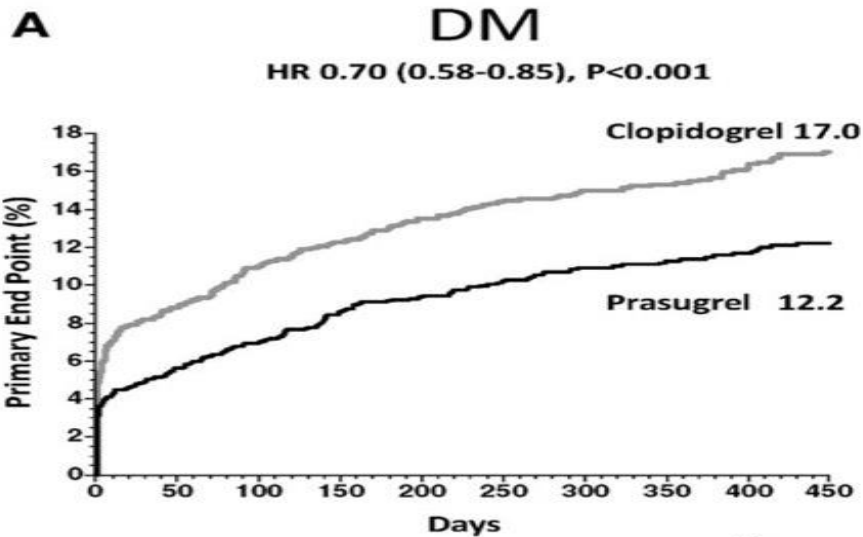
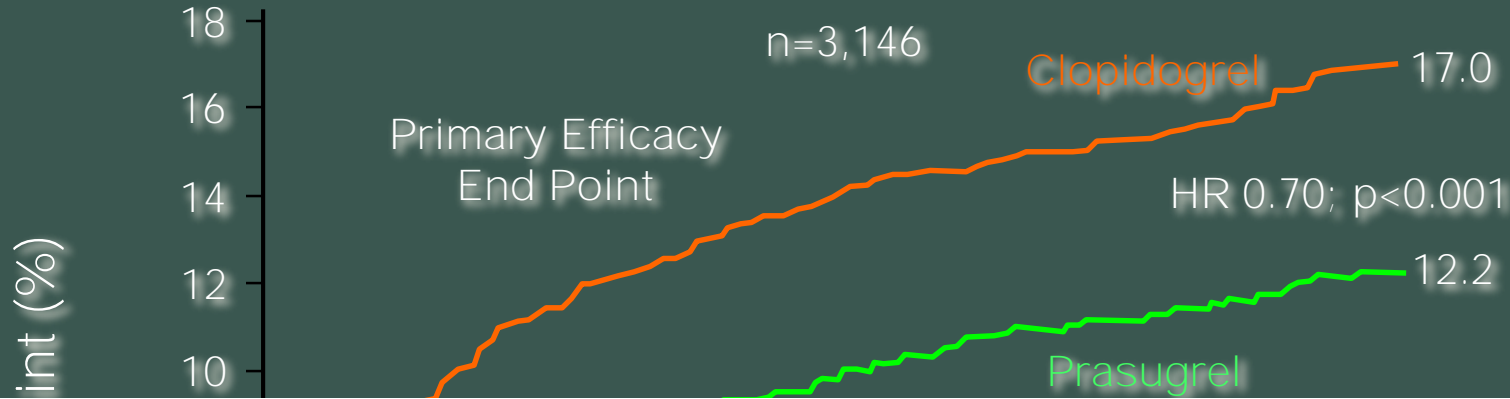
Ticagrelor versus Clopidogrel

Patients with diabetes mellitus from the PLATO trial



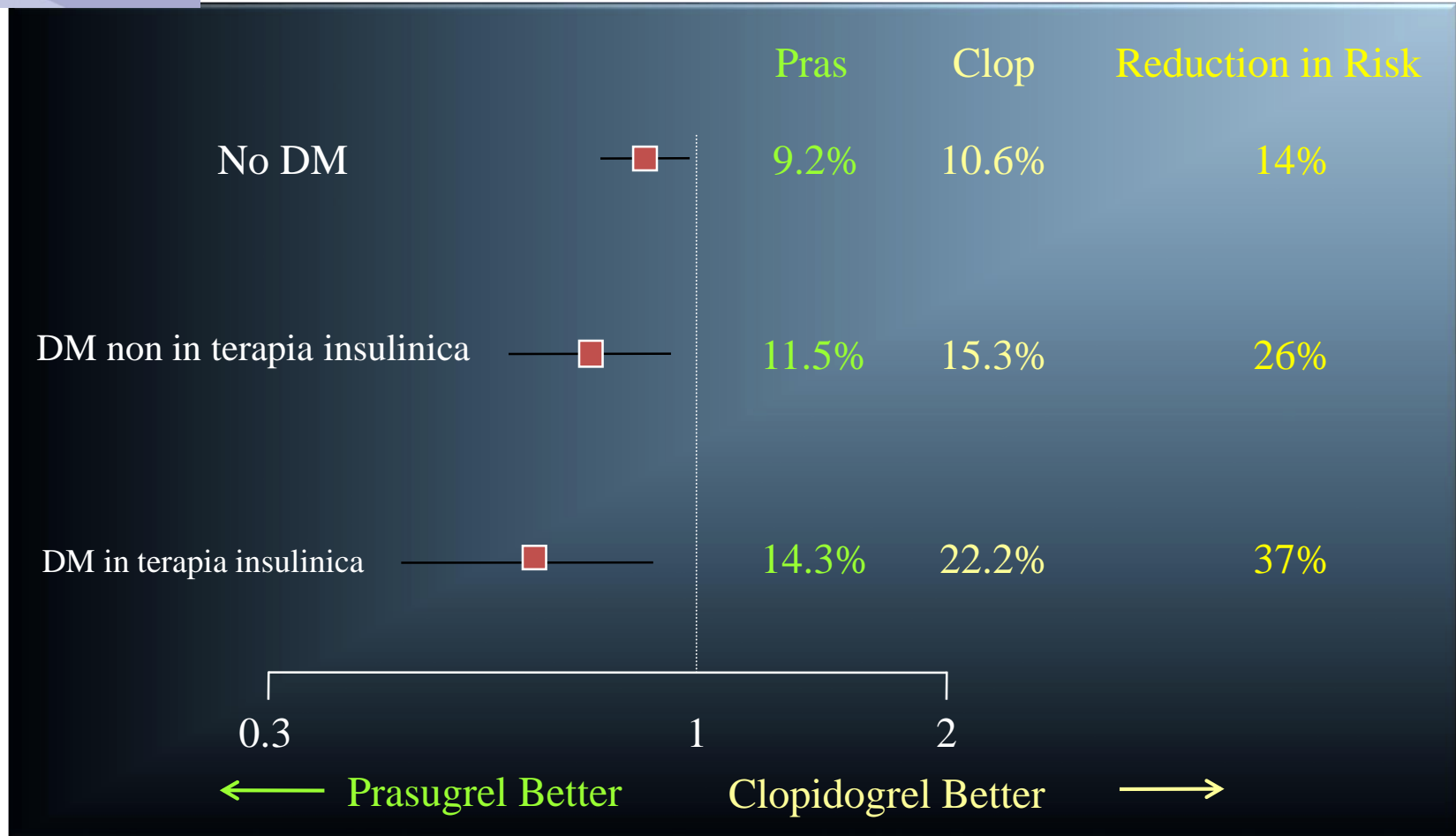
Prasugrel versus Clopidogrel

Patients with diabetes mellitus from the **TRITON-TIMI 38** trial

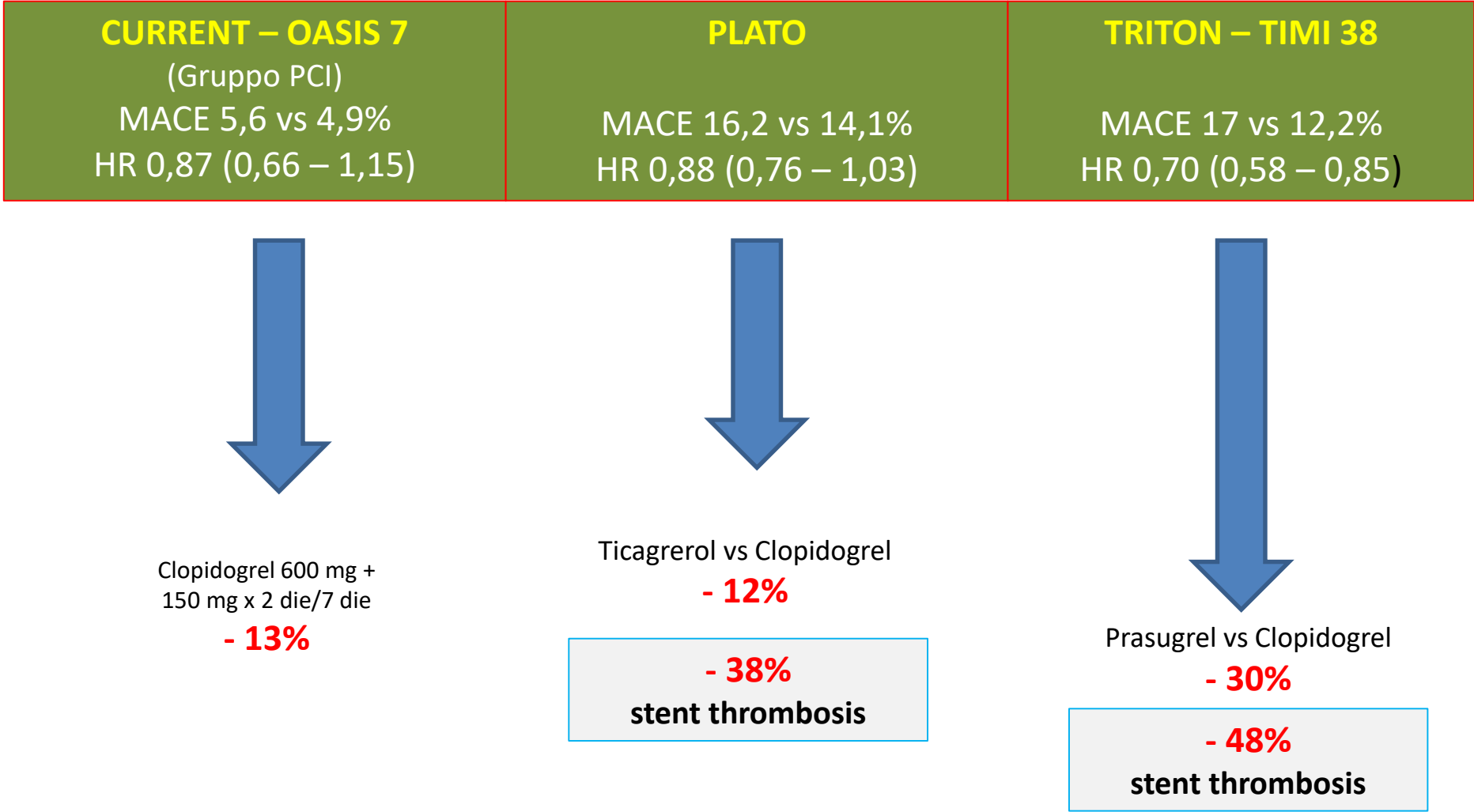


$P_{\text{interaction}} = 0.09$

Morte CV/IM/ictus per status diabetico



Efficacy of New Drugs/Approaches in Reducing Adverse Outcomes in Diabetes Mellitus From Large-Scale Clinical Trials



Recommendations for antiplatelet therapy in patients with diabetes

Antiplatelet therapy in patients with diabetes			
Recommendations	Class ^a	Level ^b	Ref. ^c
Antiplatelet therapy with aspirin in DM-patients at low CVD risk is not recommended.	III	A	184-186
Antiplatelet therapy for primary prevention may be considered in high risk patients with DM on an individual basis.	IIb	C	-
Aspirin at a dose of 75–160 mg/day is recommended as secondary prevention in DM.	I	A	182
A P2Y ₁₂ receptor blocker is recommended in patients with DM and ACS for 1 year and in those subjected to PCI (duration depending on stent type). In patients with PCI for ACS preferably prasugrel or ticagrelor should be given.	I	A	188, 189, 192, 194, 196
Clopidogrel is recommended as an alternative antiplatelet therapy in case of aspirin intolerance.	I	B	192, 197



Caso clinico

SNODO DECISIONALE 3: Terapia Antiaggregante

- Clopidogrel 300 mg
- Clopidogrel 600 mg
- Ticagerol 180 mg
- **Prasugrel 60 mg**

Table 26 Recommendations for the treatment of dyslipidaemia in diabetes

Recommendations	Class ^a	Level ^b	Ref ^c
In all patients with type 1 diabetes and in the presence of microalbuminuria and/or renal disease, LDL-C lowering (at least 50%) with statins as the first choice is recommended irrespective of the baseline LDL-C concentration.	I	C	64, 357
In patients with type 2 diabetes and CVD or CKD, and in those without CVD who are >40 years of age with one or more other CVD risk factors or markers of target organ damage, the recommended goal for LDL-C is <1.8 mmol/L (<70 mg/dL) and the secondary goal for non-HDL-C is <2.6 mmol/L (<100 mg/dL) and for apoB is <80 mg/dL.	I	B	62, 64
In all patients with type 2 diabetes and no additional risk factors and/or evidence of target organ damage, LDL-C <2.6 mmol/L (<100 mg/dL) is the primary goal. Non-HDL-C <3.4 mmol/L (<130 mg/dL) and apoB <100 mg/dL are the secondary goals.	I	B	62, 64

A target HbA1c for the reduction in risk of CVD and microvascular complications in DM of <7.0% (<53 mmol/mol) is recommended for the majority of non-pregnant adults with either type 1 or type 2 DM.

I

A

A target HbA1c of ≤6.5% (≤48 mmol/mol) should be considered at diagnosis or early in the course of type 2 DM in patients, who are not frail and do not have CVD.

IIa

B

I target terapeutici metabolici "Obbligatori"

LDL < 70 mg/dl

HbA1c < 6,5%

Conclusioni

Gli obiettivi della gestione del paziente diabetico con SCA sono:

- 1.** Anticipare la rivascolarizzazione (considerare la strategia invasiva precoce < 24 ore)
- 2.** Individualizzare la strategia di rivascolarizzazione (considerare sia opzione chirurgica che angioplastica)
- 3.** Ottimizzare la terapia antiaggregante utilizzando il miglior farmaco disponibile



La vita è un vaso invisibile e tu sei ciò che vi getti dentro.

Getta invidia, insoddisfazione e cattiveria e traboccherà ansia.

Getta gentilezza, empatia e amore e traboccherà serenità.

(Fabrizio Caramagna)