LBCT 04  Optimal Timing of Intervention in Non St-Elevation Acute Coronary Syndromes Without Pretreatment

The EARLY study

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EARLY: similarities with previous studies

**GRACE score=122**
(TIMACS=129; RIDDLE=130; LIPSIA=135; ELISA-3=135)

**GRACE score>140=26%**
(TIMACS=33%; RIDDLE=38%; LIPSIA=45%; ELISA-3=44%)

**Positive biomarker=75%**
(TIMACS=78%; RIDDLE=100%; LIPSIA=100%; ELISA-3=79%)

No effect on:
- Mortality
- MI
- urgent revascularization
- bleeding

**Time to Angio**

**Lower risk**

Adapted from Jobs et al. Lancet 2017
Non-modifiable soft endpoints

MI (biomarker)

Modifiable soft endpoints

Recurrent ischemia → CA

Risk of bias

OPEN label

Hard endpoints

Mortality

Survival for primary endpoint

HR [95% CI]: 0.17 [0.10-0.30]
p < 0.001

Days since randomization time
% of patients with recurrent ischemia while waiting

Time to angiography in the delayed groups (hrs)

- TIMACS: 3%
- Sciahbasi et al: NA
- RIDDLE-NSTEMI: 17%
- LIPSIA-NSTEMI: 6%
- ISAR-COOL: 19%
- ELISA-3: 12%
- ELISA: 13%
- ABOARD: 18%
Is this excess of RI events due to the absence of P2Y12 antagonists during the waiting period?

1/ in EARLY, 20% of patients were on P2Y12 antagonists at admission
2/ in ACCOAST (double-blind), there was no relationship between RI events and pre-treatment

Silvain et al. ACCOAST-timing, *JACC* 2018 in press
Conclusions

1. In this low (-intermediate) risk ACS population, EARLY (with no P2Y12 loading) confirms all the previous studies performed before ACCOAST, with no benefit of an immediate coronary angio on death, MI, revascularization or bleeding.

2. With the immediate angio strategy there is a trivial benefit on RI and length of stay, like in the previous studies, thus not related to pre-treatment.

3. In a strategy of « loading after seeing », EARLY has extended the ACCOAST data to P2Y12 antagonists other than prasugrel.

4. If the waiting period for a coronary angio exceeds 48hrs or, when a conservative strategy is decided, the administration of a P2Y12 antagonist needs to be considered.