SCIENTIFIC 2018 SESSIONS

LBCT 04

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

The EARLY study

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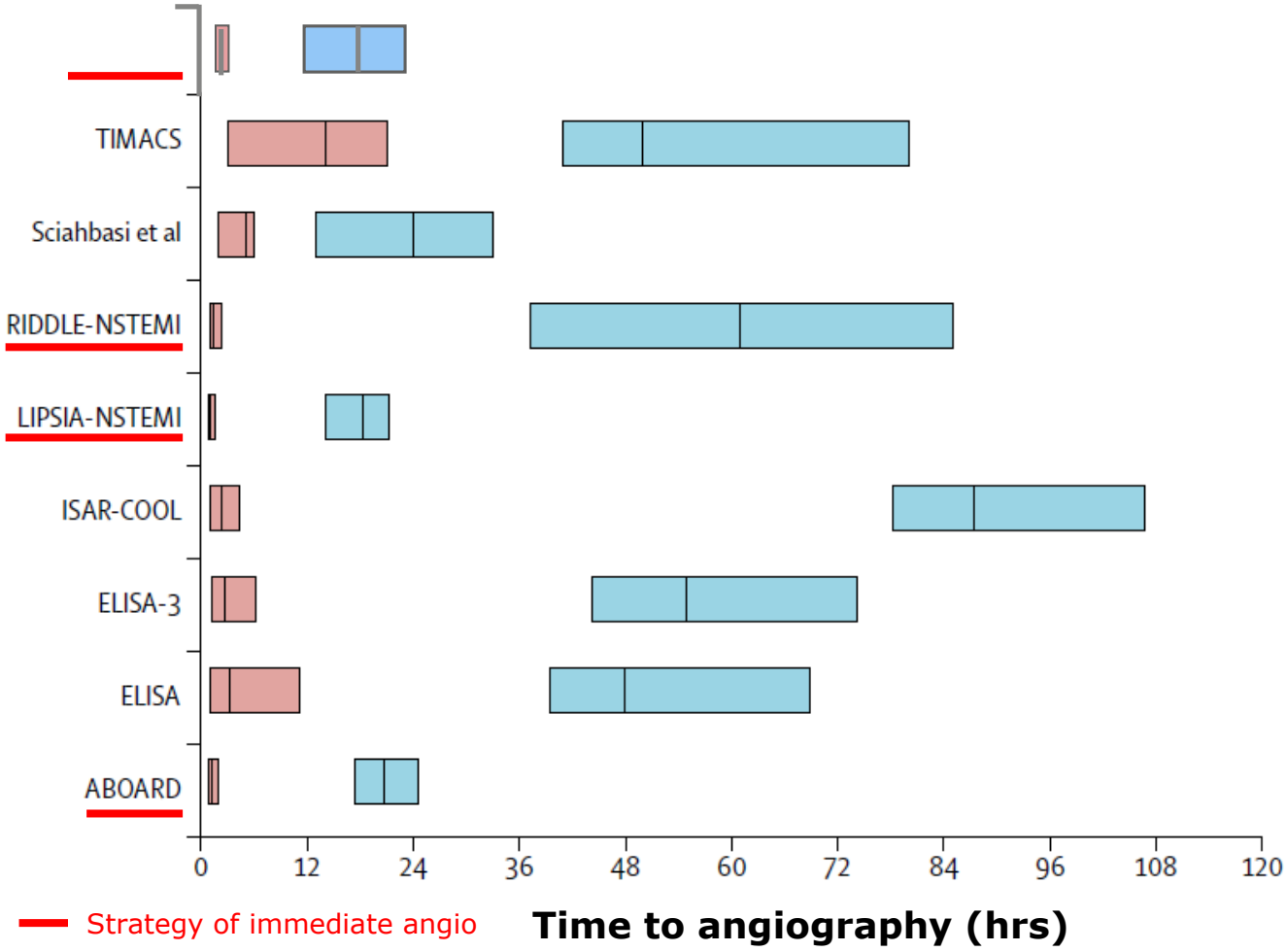
EARLY: similarities with previous studies

Time to Angio



Adapted from Jobs et al. Lancet 2017

Lower risk

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**

Mortality

Hard endpoints

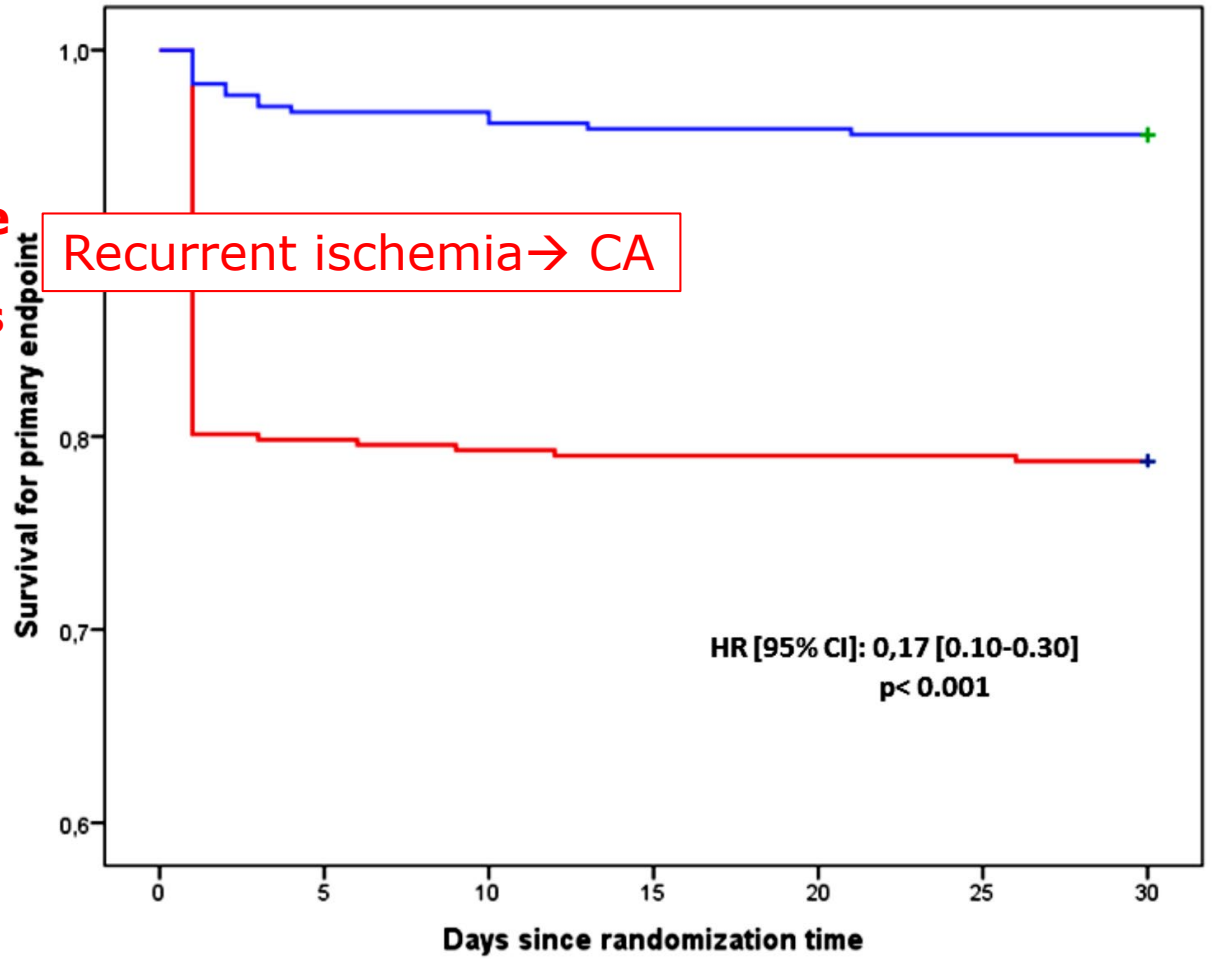
Non-modiable soft endpoints

MI (biomarker)

OPEN label

Modifiable soft endpoints

Risk of bias

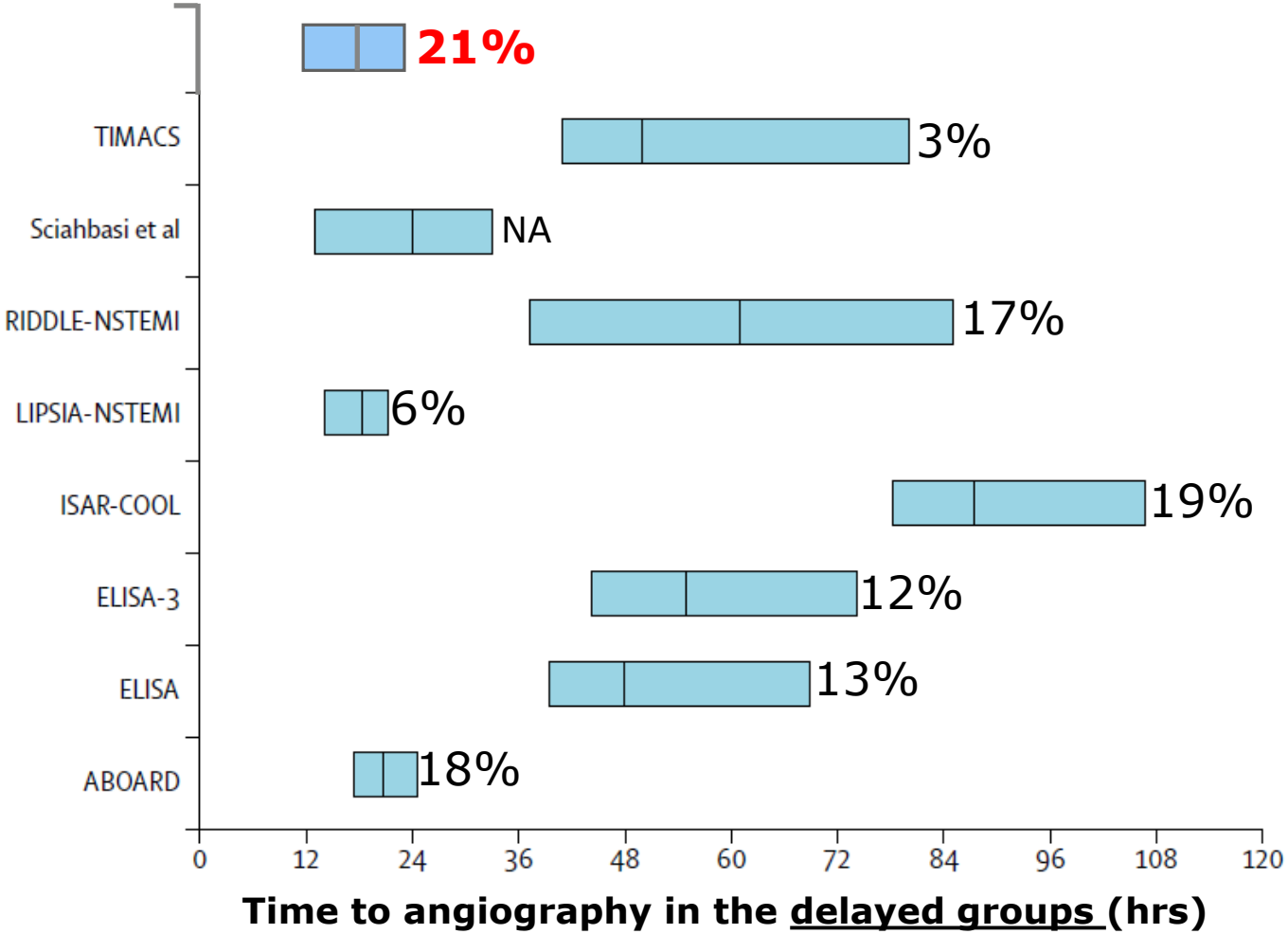


% of patients with recurrent ischemia while waiting

Adjudication criteria

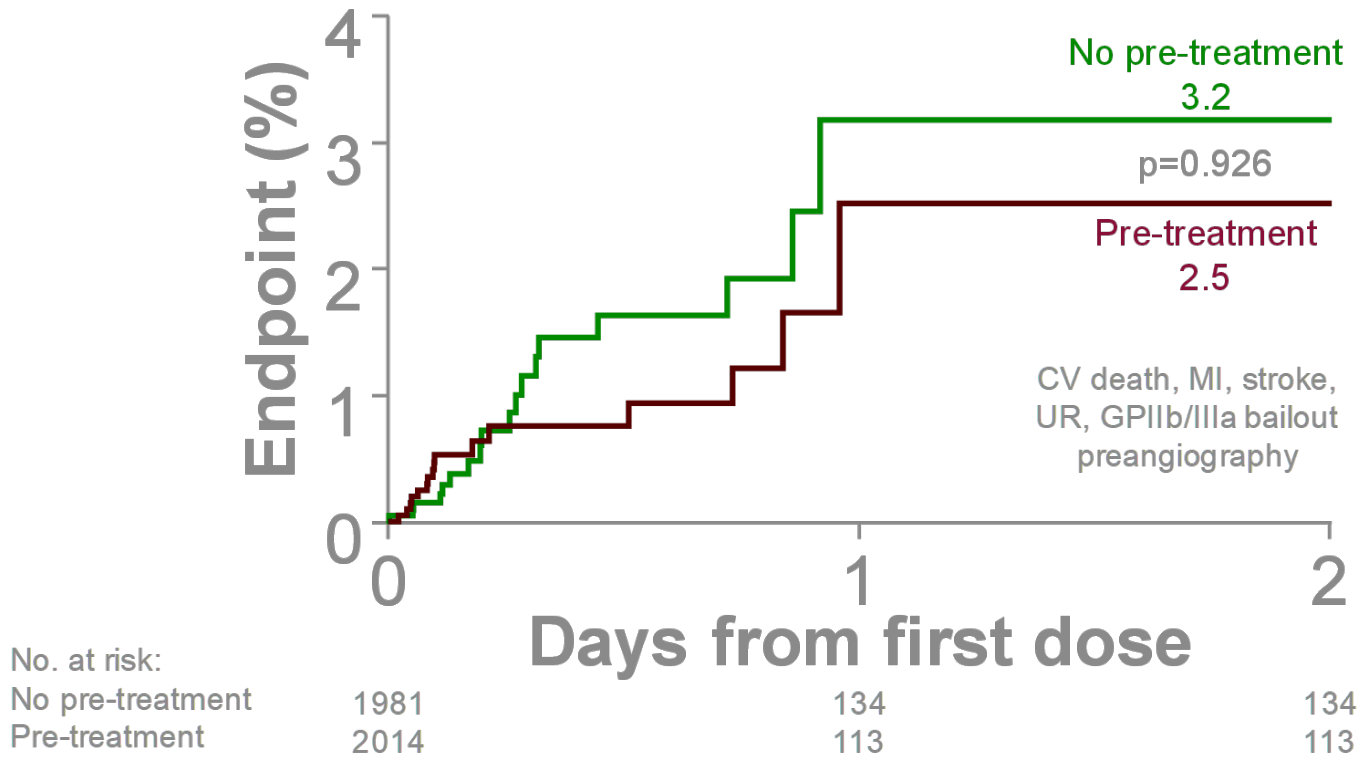
Risk level

Waiting time

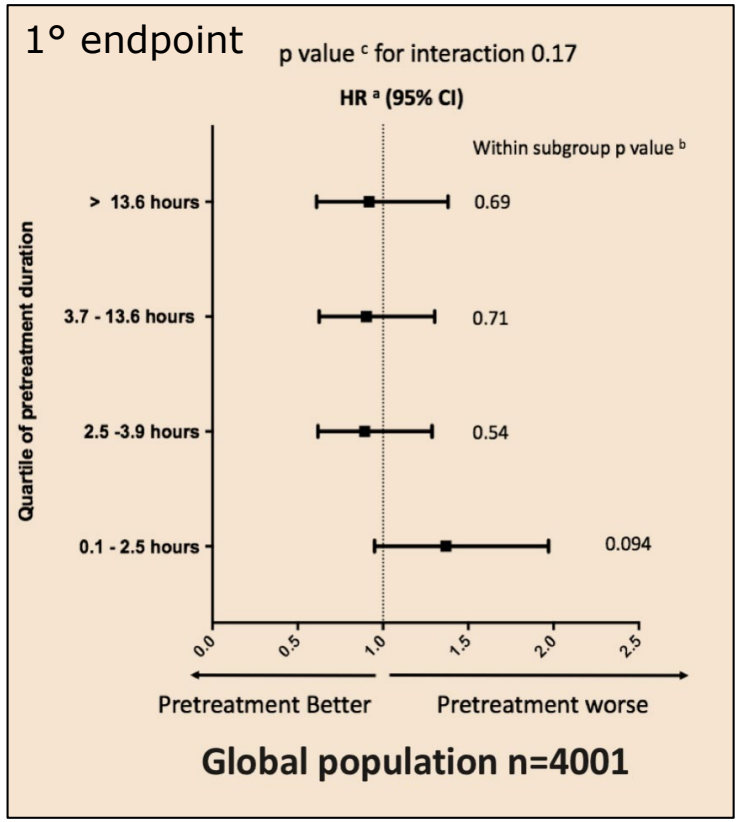


Is this excess of RI events due to the absence of P2Y12 antagonists during the waiting period?

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



Montalescot et al. *N Engl J Med* 2013;369:999–1010



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.