Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/medical-therapy-antithrombotic-management-of-padwhat-has-changed/26784/

Released: 08/20/2024
Valid until: 08/20/2025
Time needed to complete: 1h 06m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Medical Therapy: Antithrombotic Management of PAD—What Has Changed?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Bonaca:
Hi. My name is Marc Bonaca. I'm a Vascular Medicine Specialist at University of Colorado School of Medicine. I'm joined here by Dr. Manesh Patel. Manesh, do you want to introduce yourself?

Dr. Patel:
Yeah, thanks, Marc. Great to be here with you. Manesh Patel, I'm an Interventional Cardiologist at Duke University, and excited to be part of this program with you.

Dr. Bonaca:
Well, we're going to be talking about medical therapy, a lot of exciting changes in the guidelines. We're going to talk about what has changed, and maybe a deep dive into antithrombotic management. But maybe, Manesh, you could tell us your read of the guidelines, what are some of the key points and what's changed?

Dr. Patel:
Well, you know, it's actually an exciting time to be somebody taking care of patients with a vascular disease. We used to say that, you know, I'm going to put up a slide and show you all the things that have been proven to reduce limb events and events for people with PAD that have been specific to those PAD patients. And unfortunately, there weren't a lot of therapies on that slide. Now we actually have some.

So, you know, thinking about our vascular patient with lower extremity peripheral artery disease, the guidelines actually highlight several features to reduce these sort of gaps in care and improve health equity and outcomes in our PAD patients. The first is, we can think about broad athero therapy. You know, we're going to talk a lot about antithrombotic in a second, but still, some of the things like lowering blood pressure, giving specific agents like SGLT-2 agents that might improve our diabetic patients outcomes, our CKD patients outcomes, our heart failure patients outcomes, they're now indicated. Certainly, cholesterol-lowering medications, both statins, but now there are some evidence, as you and others have participated in with, some of the PCSK9 inhibitors, showing that secondary analysis, they improve both heart events and maybe some limb events. And then the big sort of step forward, I think, is we now actually, for the first time, have some therapy, specifically antithrombotic therapies, that will reduce limb events. And guidelines even have some things like cilostazol or others to reduce sort of symptomatic events in PAD patients, or at least symptoms in PAD patients.

So one of the things we're thinking about, as we do with coronary disease, is, how do we make people feel better? And then how do we make them avoid certain types of events? And now in PAD patients, some of those might be cardiovascular events, and some of those might be limb events. And depending on your patient, you have some options there.

Dr. Bonaca:
Those are great points. I mean, I think specifically as we consider antithrombotic therapy and lipid-lowering therapy, I think those two areas, but maybe we could focus a little on antithrombotic therapy. Now we're faced with choices. You know, therapies that have been shown to reduce MACE, which is, of course, critical, but ones that have also been shown to reduce major adverse limb events. And maybe you could tell us a little bit about those and how that might be considered both in the chronic setting and in the post revascularization setting.

Dr. Patel:
Well, you know, I like to say, as an interventional cardiologist, I grew up in an antiplatelet world and I'm getting closer to an antithrombotic world. You know, at one point in my life, I thought, well, once we put a stent in, and really, learnings from the coronary world that when I put a stent in, and initial generation drug alluding, since we were very worried about late-stent thrombosis, and did a lot of dual antiplatelet studies. Interestingly, as you and others that they are very limited data actually in the lower extremity with dual antiplatelet studies that have shown dramatic benefits. In fact, there's a little bit of benefit. We can go back to chronic data with CHARISMA and things like that, where there might be a little bit of benefit, but really not as much as one would hope.

More recently now, lower dose rivaroxaban, 2.5 mg BID on top of aspirin, has been shown to reduce cardiovascular events and limb events. In the COMPASS trial, a large kind of outcomes study looking at patients with both coronary and peripheral disease, and so they could have had coronary disease or coronary plus peripheral disease or vascular disease broadly, it reduced both limb and cardiovascular events. And in the VOYAGER study, which you led and I was participatory in, which in patients who were undergoing a peripheral revascularization, the addition of rivaroxaban on top of aspirin on background therapy really seemed to make a difference, both most dramatically in major adverse limb events, where people had a reduction in those repeat limb events, including really severe things like acute limb ischemia. And you can certainly speak to some of these findings too.

Dr. Bonaca:
Well, that's great. I mean, I think for the first time, having some options with proven data. You mentioned PCSK9 inhibitors and low dose rivaroxaban. I guess the big question, and it's sort of, you know, it is represented in the guidelines, but you and Jen wrote the paper on the endovascular subgroup, everyone wants to know what to do with dapt, or when to add riva. What do you - what do the guidelines say? What do you think?

Dr. Patel:
Yeah, well, I'll just say that the guidelines think that you know that low-dose riva is Class 1 as to reduce MALE, I'm sorry, in these patients undergoing revascularization, which is a great step forward thanks to research, as we've discussed. In the endovascular group, which is, I think, a really critical one, it's still hard for us to let go of clopidogrel sometimes, you know. So what I've at least told my colleagues is, if you want to use clopidogrel, you can, you just got to make sure that they're both on aspirin and rivaroxaban 2.5 BID. And what we've shown is that prolonged, and many people in the study actually didn't prolong it out to 6 months, some of the drug coded products have a label where you could, most of the patients in the study only had to go about 30 days. And you can use it or not. It didn't seem to have a huge efficacy effect. And bleeding was similar at that low - at that shorter period. If you start to really extend it, then bleeding does go up. So our recommendation is, if you want to use it, you can, but don't use it beyond 30 days.

Dr. Bonaca:
Alright. Well, thank you. It's been a pleasure to talk about the medical therapy in the guidelines. Thank you very much for your attention.

Announcer:
You've been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative, GLC and Total CME, LLC and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.