Triple antithrombotic therapy in the context of the latest European Society of Cardiology Guidelines

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Acute coronary syndromes (ACS), including unstable angina/non-ST segment elevation myocardial infarction (NSTE-ACS) andST- segment elevation myocardial infarction (STEMI), constitute another cardiovascular disease entity with associated risks of mortality and morbidity from myocardial infarction (MI), heart failure, and ventricular arrhythmias.Atrial fibrillation (AF) is associates with a significant risk of mortality and morbidity from stroke and thrombo-embolism. Stroke prevention is central to the management of AF patients. Atrial fibrillation complicating an ST-elevation (STE) or non-STE (NSTE) ACS and vice versa is relatively frequent, and isassociated with significantly higher mortality rates as well as higher rates of ischaemic and bleeding events in AF patients, stroke risk must be assessed using the CHA2-DS2-VASc score, and bleeding risk assessed using the HAS-BLED score. Risk stratification is a dynamic process, and must be performed at regular intervals. Where adjusted dose VKA is used, good quality anticoagulation control is recommended, with a TTR.70% When VKA is given in combination with clopidogrel and/or low-dose aspirin, the dose intensity of VKA should be carefully regulated, with a target INR range of 2.0–2.5 Where aNOACis used in combination with clopidogrel and/or low-dose aspirin, the lower tested dose for stroke prevention in AF (that is, dabigatran 110 mg b.i.d., rivaroxaban 15 mg o.d. or apixaban 2.5 mg b.i.d.) may be considered.

Key words: acute coronary syndrome, atrial fibrillation, triple antithrombotic therapy