

Congreso de la **SAC24**
Sociedad Asturiana
de **Cardiología** **17 y 18 de mayo**



**DAI en Prevención
Primaria:
Situaciones Complejas**

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#AsturCardio2024

Situaciones Complejas

- Sd. Coronario Agudo:
 - Contexto precoz
 - Vasoespasmos
 - Disfunción moderada >40d
- Displasia Arritmogénica.
- Sd. de Brugada.
- QT Largo

Síndrome Coronario Agudo

Importancia del tiempo de presentación

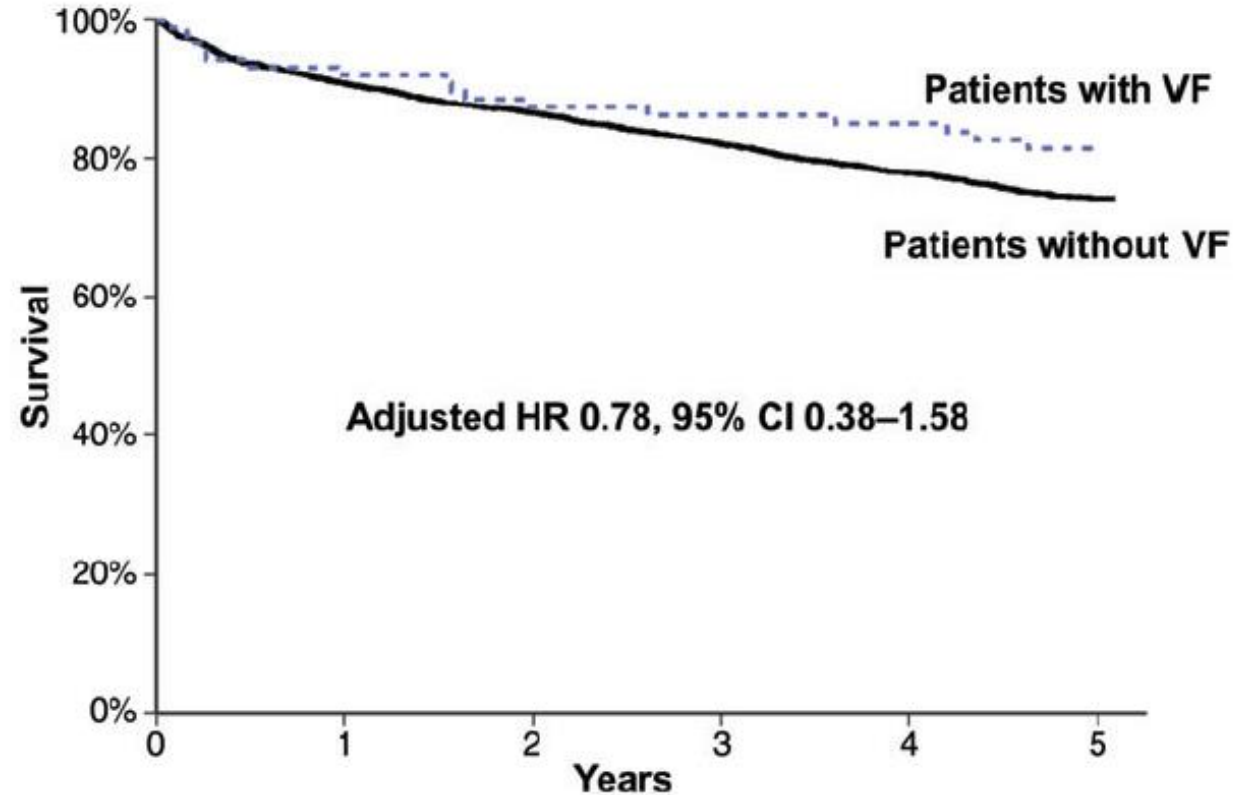
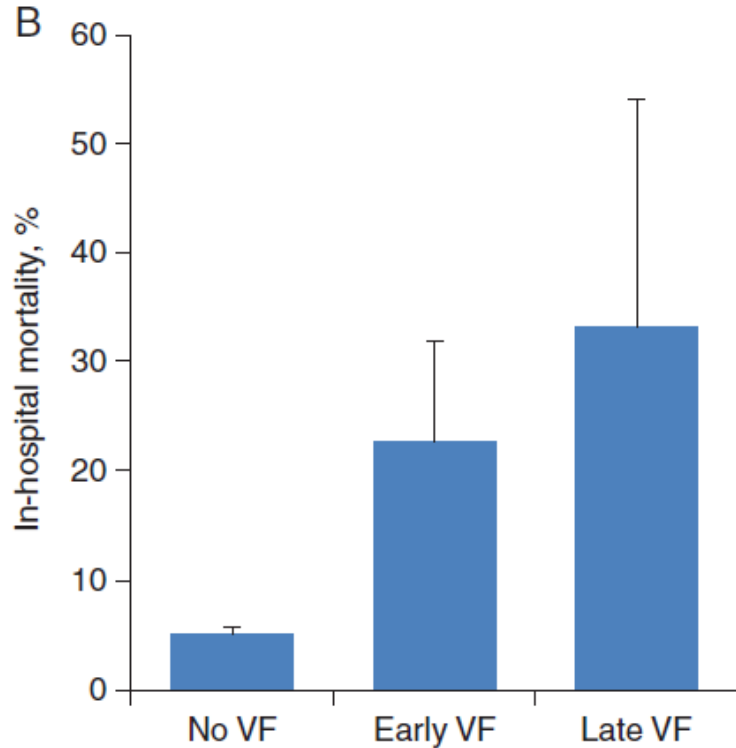
- Clásicamente mejor pronóstico <48h
- Diferente papel de la FV frente a TVM
- Aparición tardía (>48h)
- Disfunción primeros 40 días

Incidence of sudden cardiac death after ventricular fibrillation complicating acute myocardial infarction: a 5-year cause-of-death analysis of the FAST-MI 2005 registry[†]

Wulfran Bougouin^{1,2,3}, Eloi Marijon^{1,2,3}, Etienne Puymirat^{1,2,3}, Pascal Defaye⁴,



European Heart Journal (2014) 35, 116–122
doi:10.1093/eurheartj/eh453



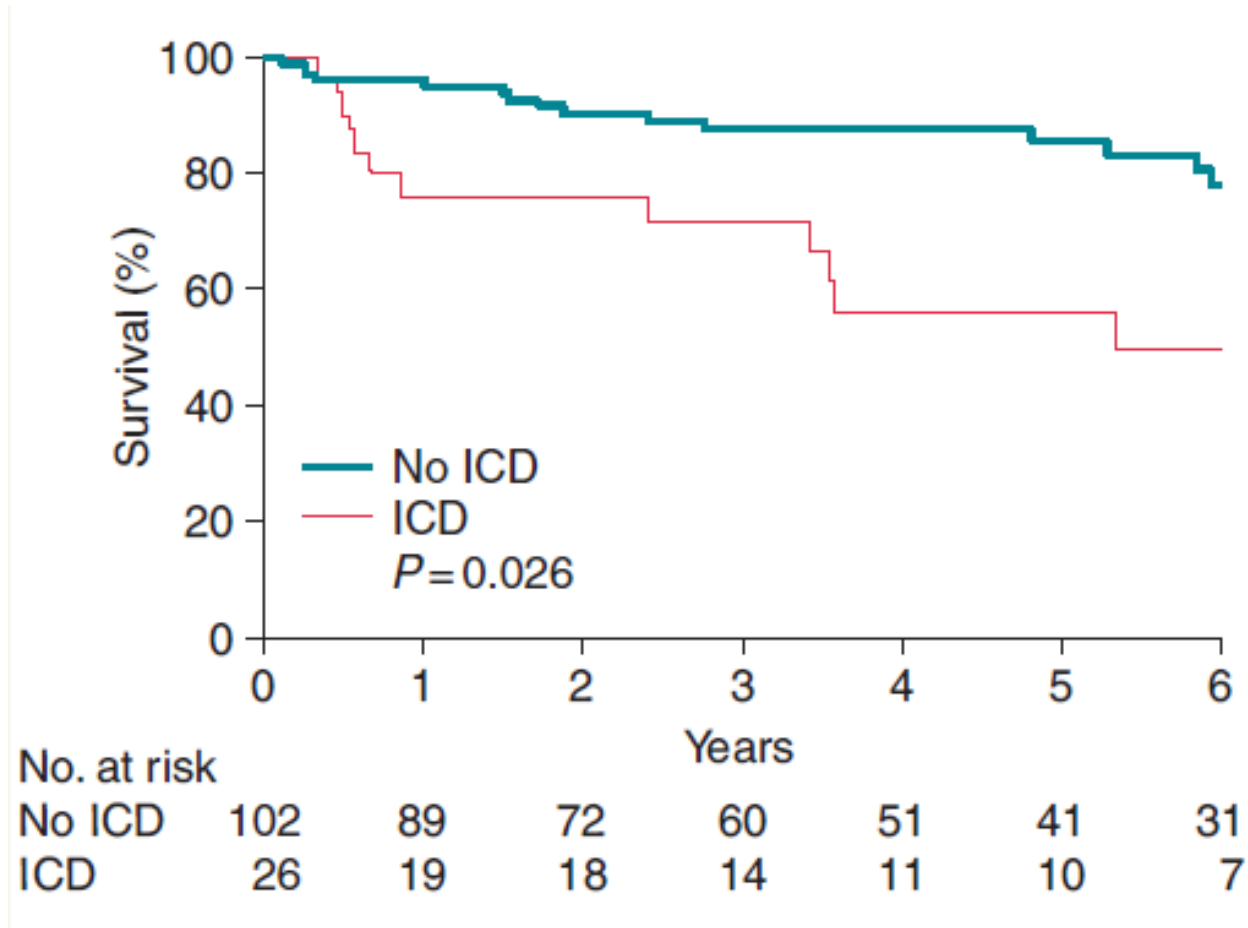
Number at risk	Discharge	1 year	2 years	3 years	4 years	5 years
Patients with VF	87	80	76	74	71	55
Patients without VF	3376	3053	2873	2705	2526	1787

Outcomes in patients with sustained ventricular tachyarrhythmias occurring within 48 h of acute myocardial infarction: when is ICD appropriate?

Jackson J. Liang¹, David O. Hodge², Ramila A. Mehta², Andrea M. Russo³,
Abhiram Prasad^{4,5}, and Yong-Mei Cha^{4*}



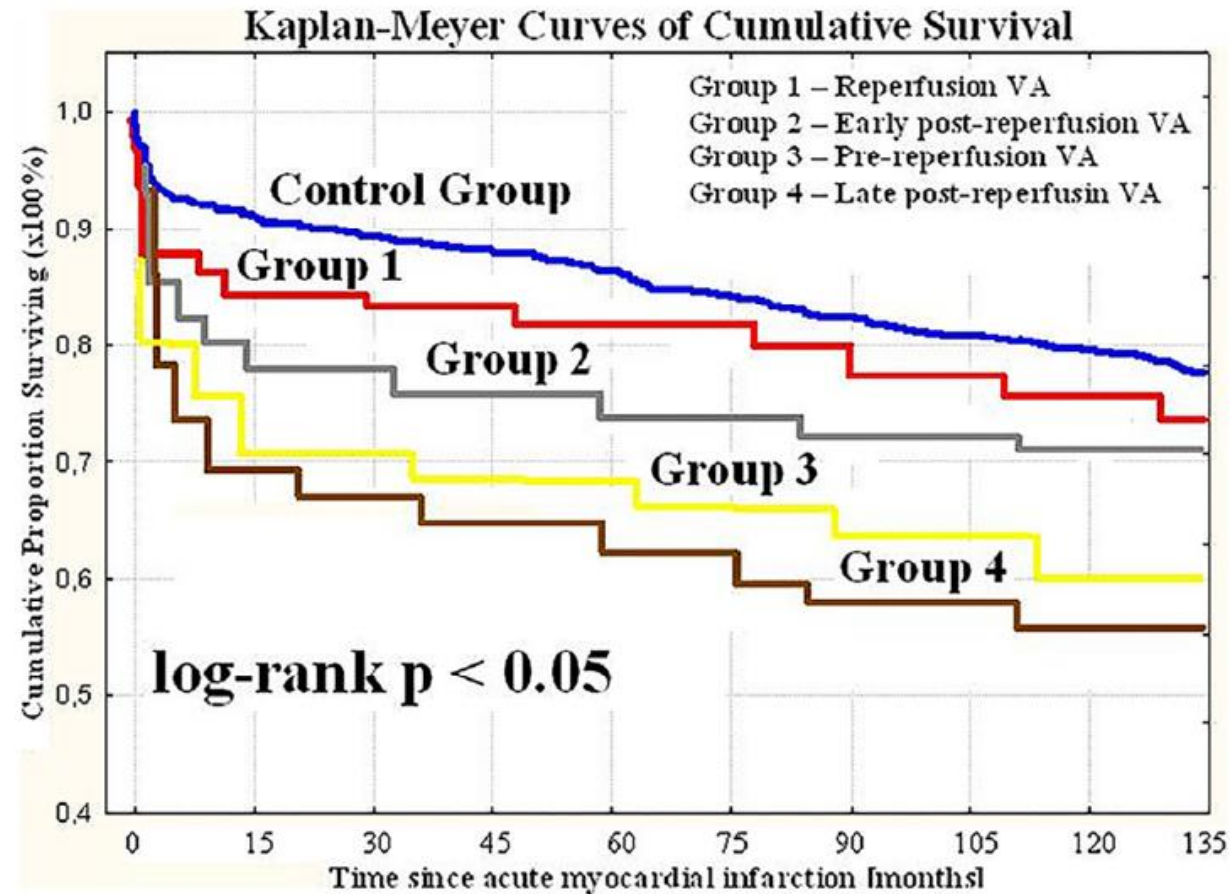
Europace (2014) 16, 1759–1766
doi:10.1093/europace/euu138



Prognostic Significance of Complex Ventricular Arrhythmias Complicating ST-Segment Elevation Myocardial Infarction

Tomasz Podolecki, MD^{a,*}, Radoslaw Lenarczyk, MD^a, Jacek Kowalczyk, MD^a,

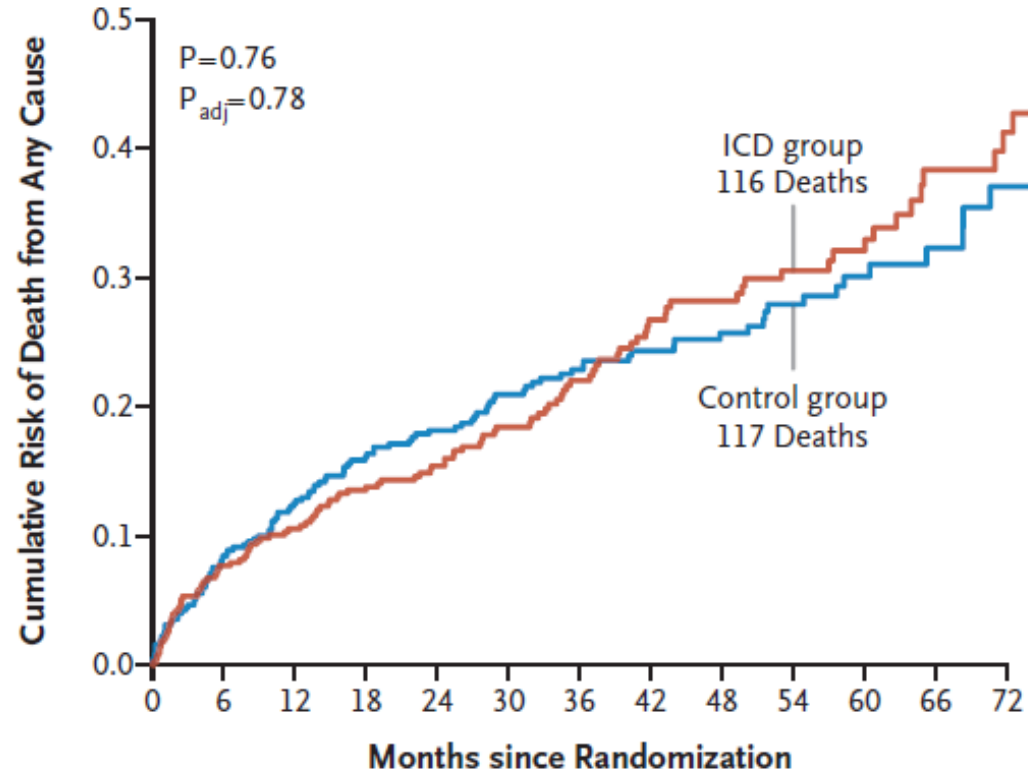
(Am J Cardiol 2018;121:805–809)



Defibrillator Implantation Early after Myocardial Infarction

Gerhard Steinbeck, M.D., Dietrich Andresen, M.D., Karlheinz Seidl, M.D., Johannes Brachmann, M.D.,

N ENGL J MED 361;15 NEJM.ORG OCTOBER 8, 2009



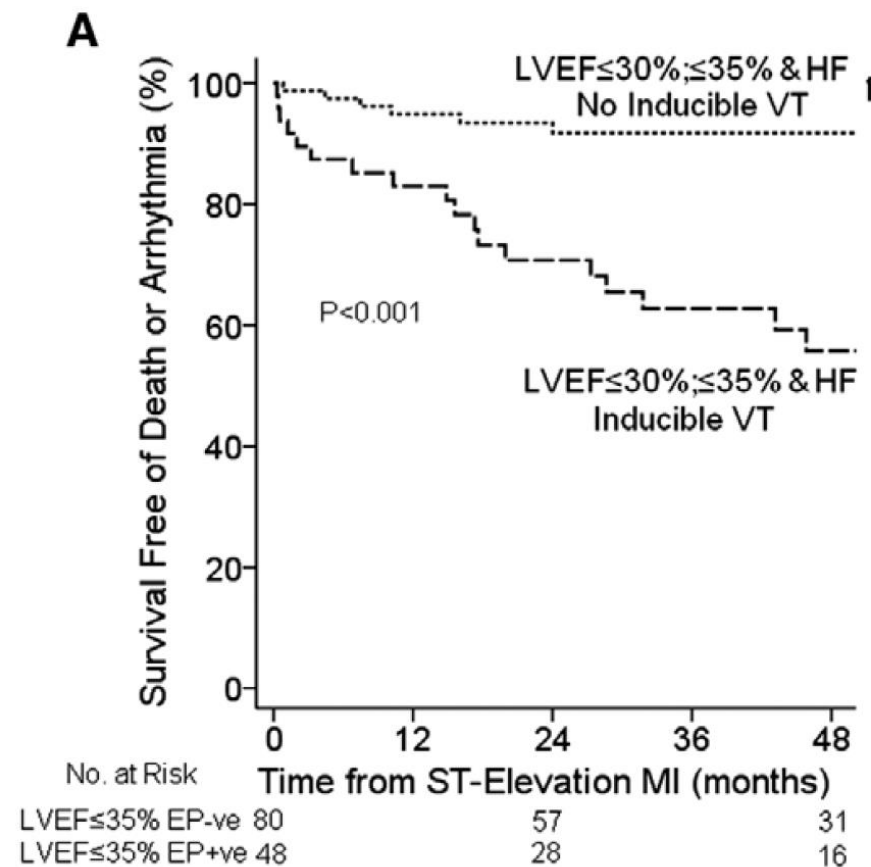
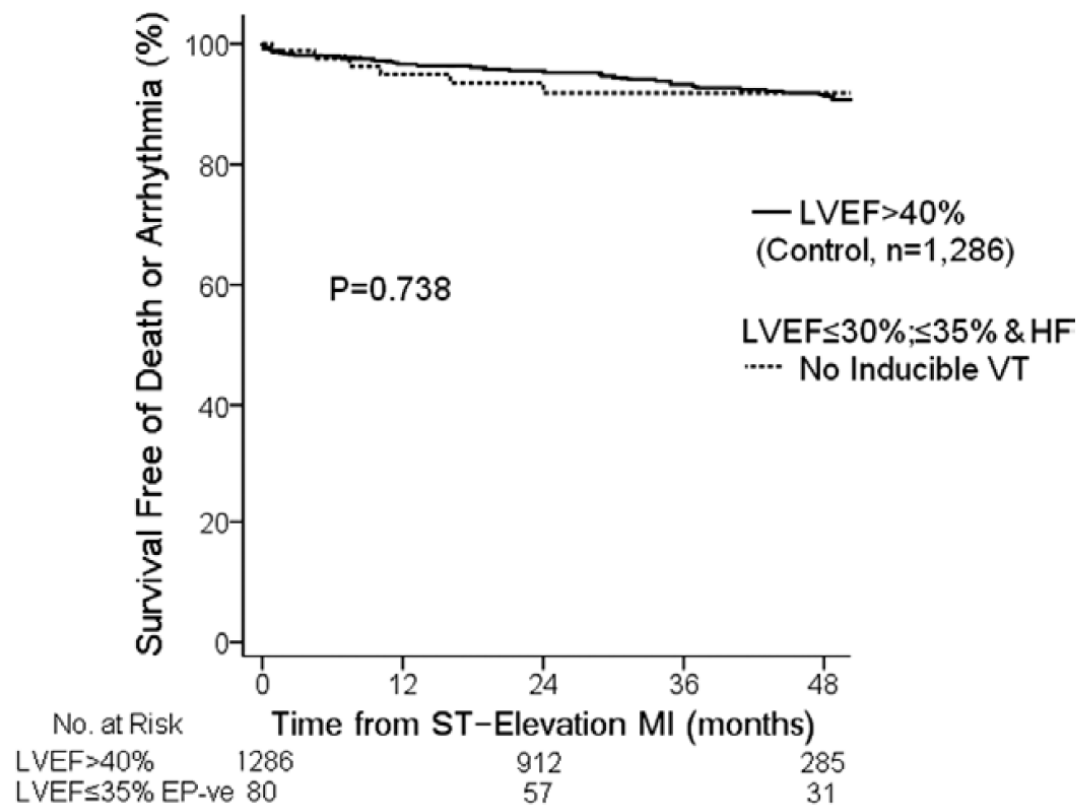
No. at Risk

ICD group	445	390	366	338	303	253	207	163	137	106	78	48	40
Control group	453	410	380	336	307	267	230	187	151	118	79	49	36

Long-Term Arrhythmia-Free Survival in Patients With Severe Left Ventricular Dysfunction and No Inducible Ventricular Tachycardia After Myocardial Infarction

Sarah Zaman, MBBS; Arun Narayan, RN; Aravinda Thiagalingam, MBBS, PhD;

(*Circulation*. 2014;129:848-854.)



Vasoespasmo

Long-term prognosis of patients with life-threatening ventricular arrhythmias induced by coronary artery spasm

Moisés Rodríguez-Mañero^{1*}, Teresa Oloriz², Jean-Benoit le Polain de Waroux³,

- 49 p con FV y vasoespasmo documentado como causa.
- 13 p desarrollan FV en el seguimiento.
- Buna respuesta tras titular CA.



Europace (2017) 0, 1–8
doi:10.1093/europace/eux052

Vasospasm		
In SCA survivors with coronary artery spasm, implantation of an ICD should be considered. ^{562–564}	Ila	C

Disfunción Moderada > 40 días

Arrhythmic risk stratification in post-myocardial infarction patients with preserved ejection fraction: the PRESERVE EF study

Konstantinos A. Gatzoulis ^{1*}, Dimitrios Tsiachris¹, Petros Arsenos¹,



ESC

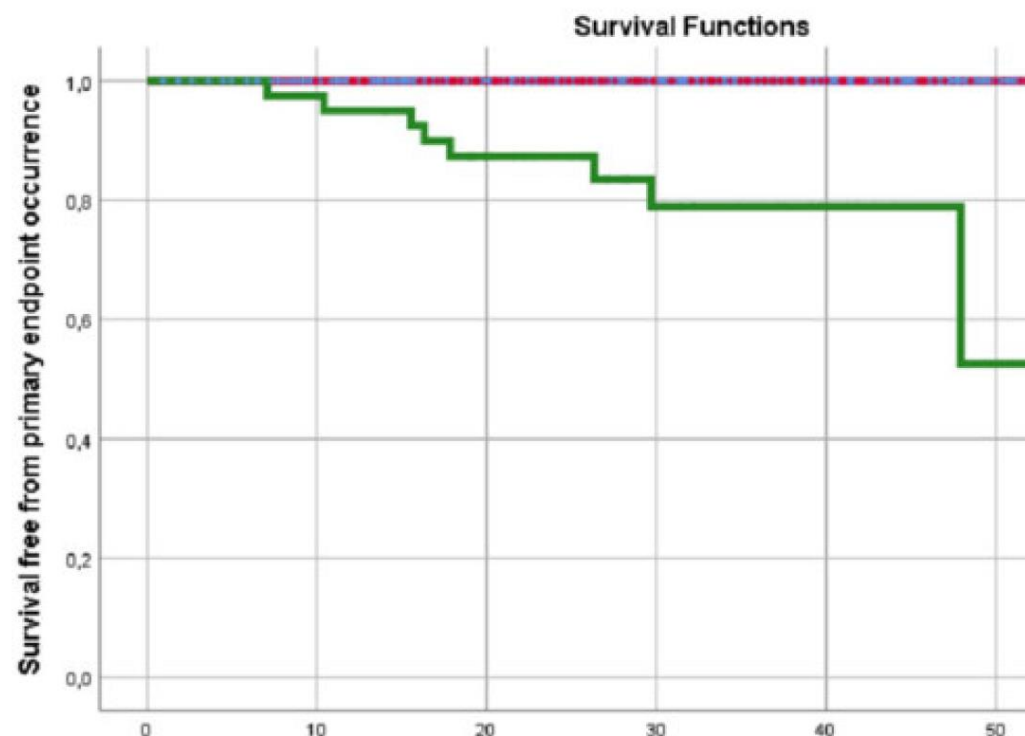
European Society of Cardiology

European Heart Journal (2019) 0, 1–10

doi:10.1093/eurheartj/ehz260

Criterios de EEF:

- >30 EVs /h
- TVNS en holter
- QTc > 440 ms
- Ondas T alternantes
- Baja variabilidad de FC

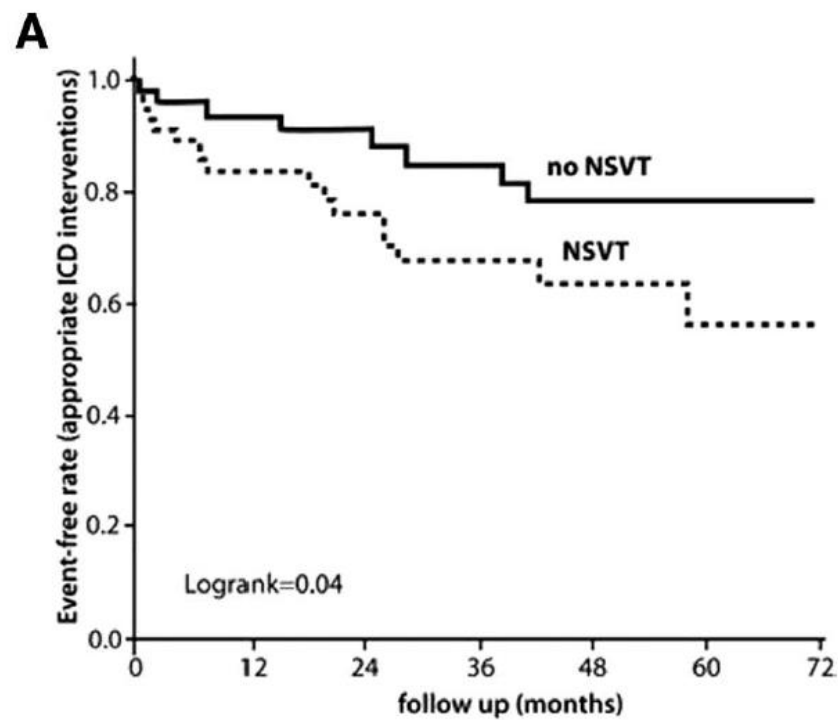
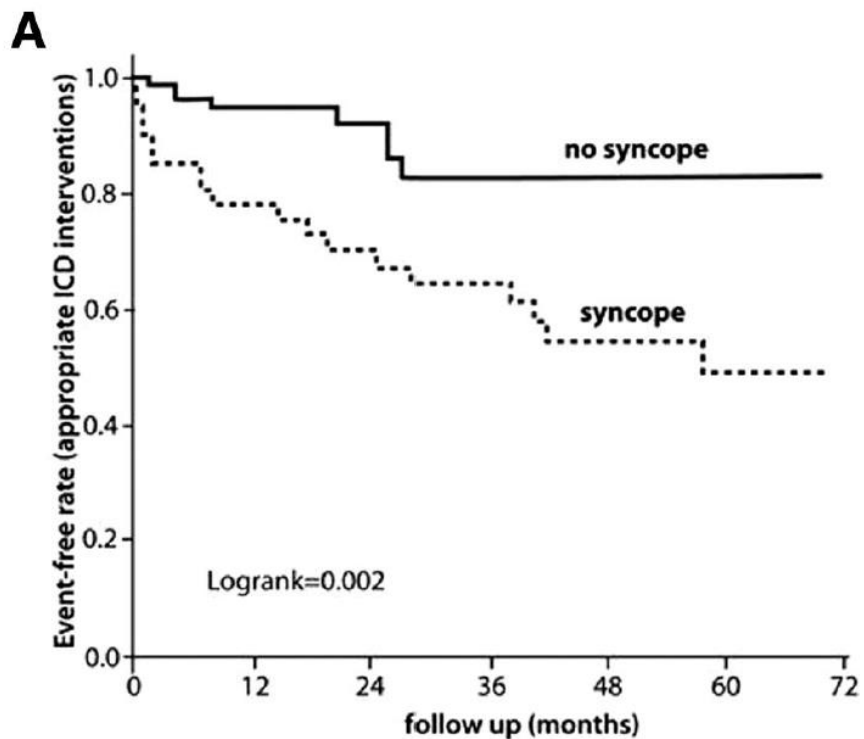


Displasia Arritmogénica

Prophylactic Implantable Defibrillator in Patients With Arrhythmogenic Right Ventricular Cardiomyopathy/ Dysplasia and No Prior Ventricular Fibrillation or Sustained Ventricular Tachycardia

Domenico Corrado, MD, PhD; Hugh Calkins, MD; Mark S. Link, MD; Loira Leoni, MD, PhD;

Circulation September 21, 2010

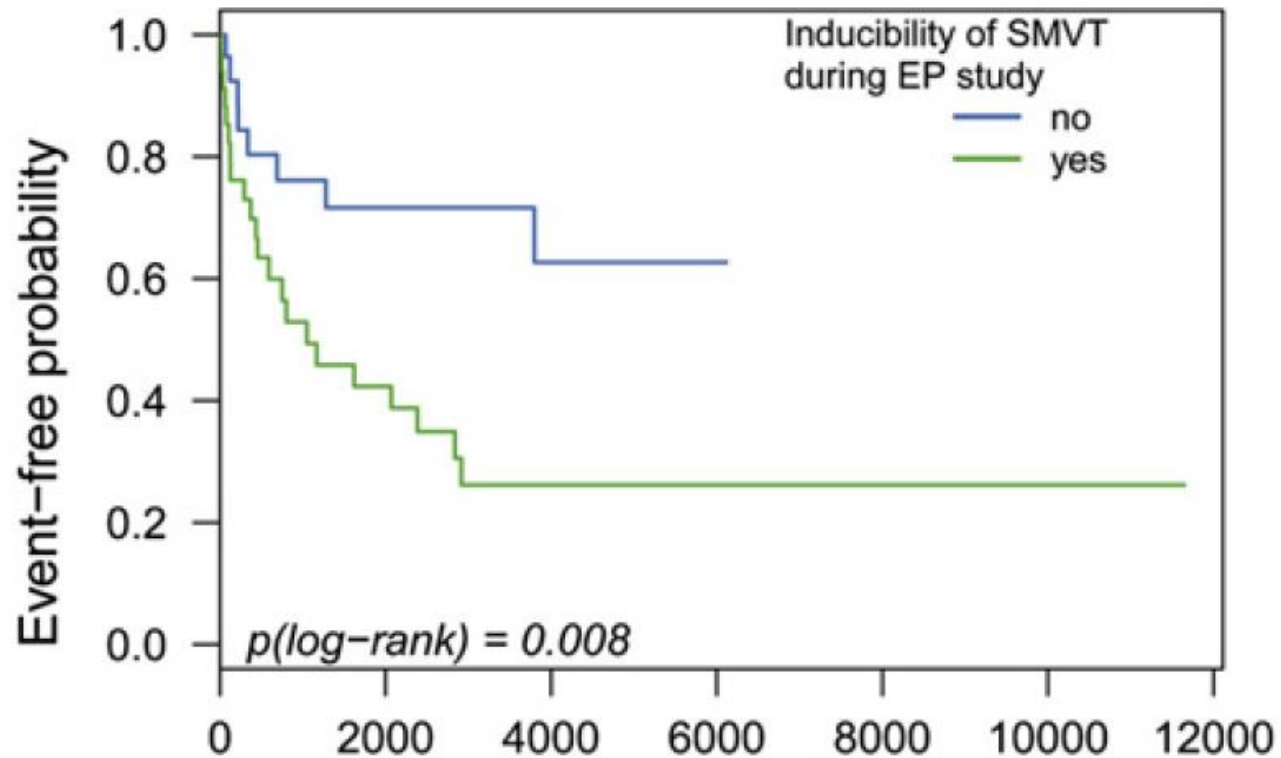


no NSVT	50	39	30	25	21	11	8
NSVT	56	38	28	21	14	6	4

Usefulness of Inducible Ventricular Tachycardia to Predict Long-Term Adverse Outcomes in Arrhythmogenic Right Ventricular Cardiomyopathy

Ardan M. Saguner, MD^{a,*}, Argelia Medeiros-Domingo, MD, PhD^a, Moritz A. Schwyzer, BMed^a,

(Am J Cardiol 2013;111:250–257)



Displasia Arritmogénica

ICD implantation should be considered in patients with definite ARVC and an arrhythmic syncope. ^{696,701,711–713}	Ila	B
ICD implantation should be considered in patients with definite ARVC and severe RV or LV systolic dysfunction. ^{675,691}	Ila	C
ICD implantation should be considered in symptomatic ^d patients with definite ARVC, moderate right or left ventricular dysfunction, and either NSVT or inducibility of SMVT at PES. ^{695,696,701,703,705}	Ila	C
In patients with ARVC and symptoms highly suspicious for VA, PES may be considered for risk stratification. ^{695,705}	Ilb	C

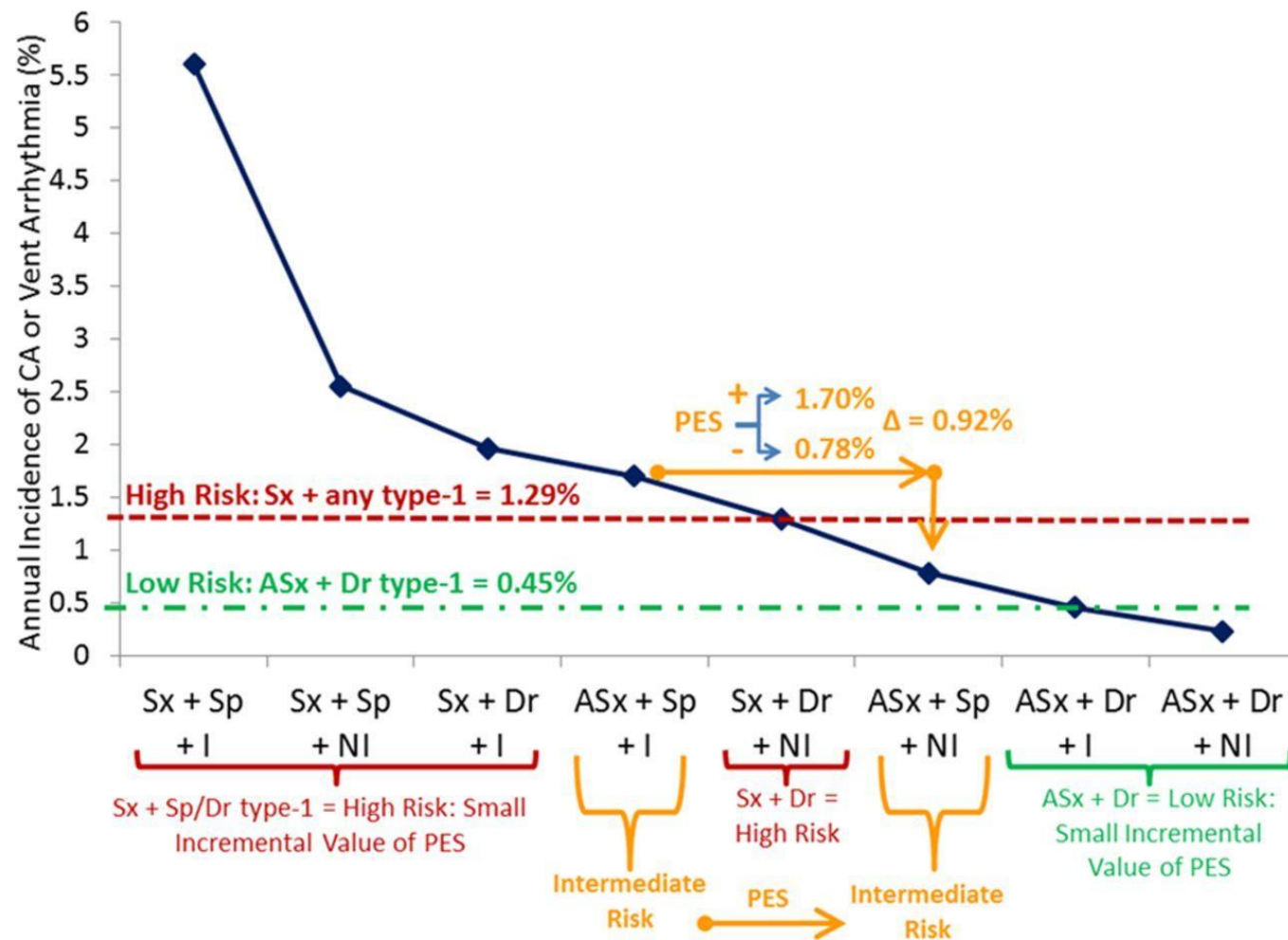
Síndrome de Brugada

Programmed Ventricular Stimulation for Risk Stratification in the Brugada Syndrome

A Pooled Analysis

Jakub Sroubek, MD, PhD; Vincent Probst, MD, PhD; Andrea Mazzanti, MD;

(Circulation. 2016;133:622-630.)



Síndrome de Brugada

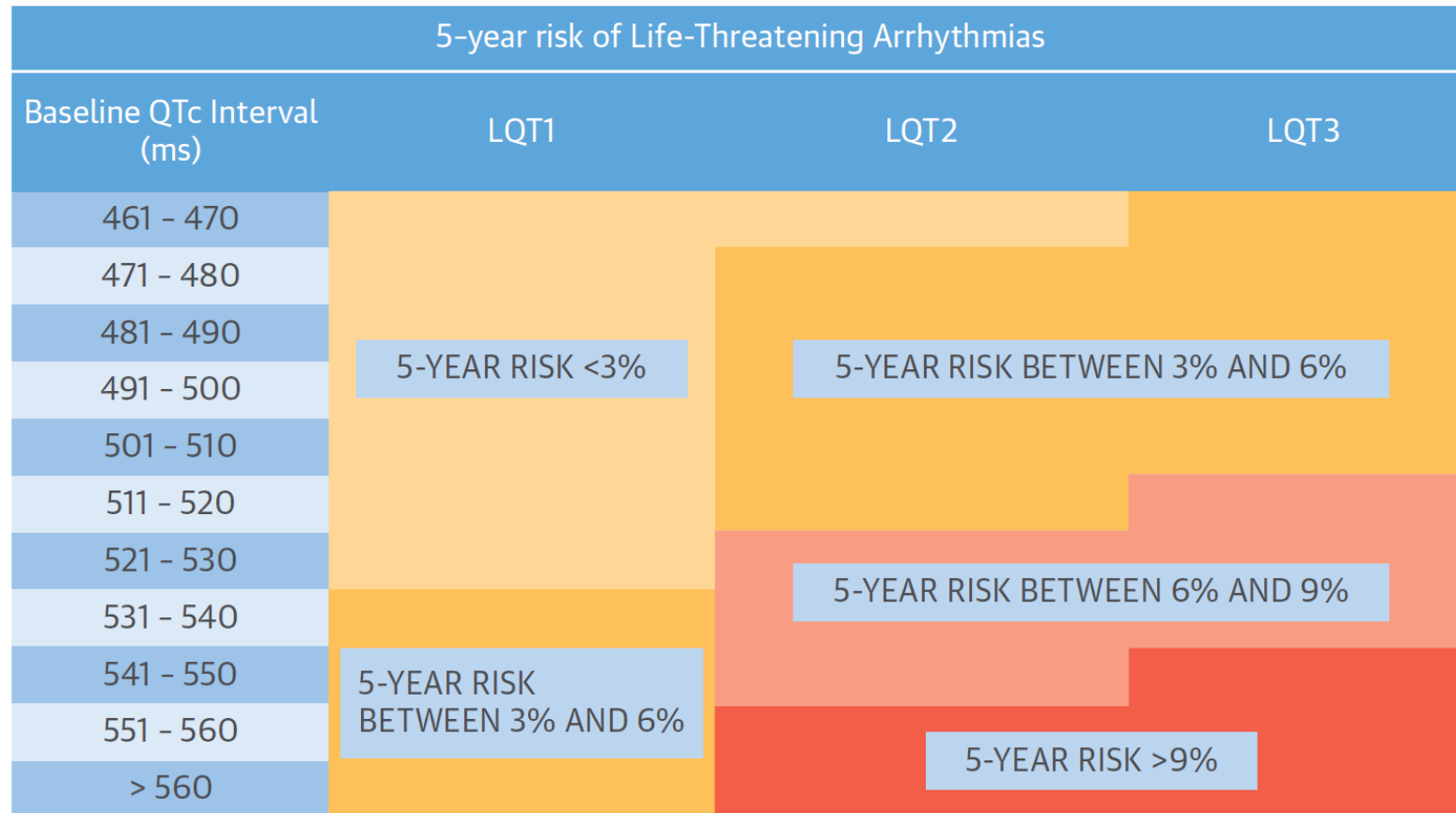
ICD implantation should be considered in patients with type 1 Brugada pattern and an arrhythmic syncope. ^{990,992,996}	IIa	C
Implantation of a loop recorder should be considered in BrS patients with an unexplained syncope. ^{997,999}	IIa	C
PES may be considered in asymptomatic patients with a spontaneous type I BrS ECG. ¹⁵⁵	IIb	B
ICD implantation may be considered in selected asymptomatic BrS patients with inducible VF during PES using up to 2 extra stimuli. ¹⁵⁵	IIb	C

QT Largo

Interplay Between Genetic Substrate, QTc Duration, and Arrhythmia Risk in Patients With Long QT Syndrome

Andrea Mazzanti, MD,^{a,b} Riccardo Maragna, MD,^a Gaetano Vacanti, MD,^a Nicola Monteforte, MD,^a

JACC VOL. 71, NO. 15, 2018



QT Largo

Beta-blockers, ideally non-selective beta-blockers (nadolol or propranolol), are recommended in LQTS patients with documented QT interval prolongation, to reduce risk of arrhythmic events. ^{940,945,946}	I	B
ICD implantation is recommended in patients with LQTS who are symptomatic ^d while receiving beta-blockers and genotype-specific therapies.	I	C
Either ICD implantation or LCSD should be considered in patients with symptomatic ^d LQTS, when beta-blockers and genotype-specific therapies are not tolerated or contraindicated at the therapeutic dose.	IIa	C
In LQTS, it should be considered to calculate the arrhythmic risk before initiation of therapy based on the genotype and the duration of QTc interval. ⁹⁴⁰	IIa	C

Muchas Gracias