Abstract: P2168

Endovascular treatment of ischemic heart disease in patients with blood cancer

Authors:
E Gitelzon¹, A Faybushevich¹, V Baranovich¹, G Veretnik¹, D Maximkin¹, D Gitelson¹, ¹Peoples Friendship University of Russia (PFUR) - Moscow - Russian Federation,

Topic(s):
Cardio-Oncology

Citation:

Funding Acknowledgements:
The publication has been prepared with the support of the 'RUDN University Program 5-100'

Improvement of the treatment setting for oncohematological diseases allowed to improve the treatment results, to increase the life expectancy, to change life quality. This is one of the factors explaining the tendency of the increase in the incidence of coronary heart disease with oncological disease combination.

Materials and methods. Our study included two-stage treatment of 54 patients with coronary artery disease and blood cancer. The average age was 64 ± 11.63 years. The 1st stage was performed percutaneous coronary intervention, the 2nd - the treatment of oncopathology (11 patients underwent surgical treatment, 43–chemotherapy/radiation therapy). All patients were prescribed double antiplatelet therapy before revascularization (acetylsalicylic acid at a dose of 100 mg/day and clopidogrel at a dose of 75 mg/day). Immediately before myocardial revascularization the level of platelet aggregation was assessed by the method of light transmission aggregometry of platelets with adenosine diphosphate (the target level of platelet aggregation before performing percutaneous coronary intervention is less than 45%). We chose the stent type individually based on the duration of the surgical intervention by the reason of cancer, anatomy of the coronary arteries and the nature of coronary arteries atherosclerotic lesions. If surgical intervention was planned for 1 month after percutaneous coronary intervention, then bare-metal stents were preferred. There were no intraoperative and hospital mortality and also no mortality cases due to coronary artery disease during the 1st year after percutaneous coronary intervention. All patients received dual antiplatelet therapy for at least 1 month before performing surgical treatment of oncopathology if bare-metal stents was implanted and 3 months - if drug-eluting stents. Dual antiplatelet therapy was stopped 5–7 days before the surgical treatment replaced by unfractionated heparin to prevent thrombotic and hemorrhagic complications. After the surgery dual antiplatelet therapy was restarted in 6-48 hours. During the 1st year after percutaneous coronary intervention the recurrent angina was observed in 2 patients. Hemodynamically significant 'in-stent' restenoses were identified on the coronary angiography. In 1 patient the recurrent angina occurred 4 months after myocardial revascularization with bare-metal stent implantation. In the 2nd patient the recurrent angina was observed 11 months after previously performed percutaneous coronary intervention with drug-eluting stent.

Conclusion. Percutaneous coronary intervention is an effective and safe method of myocardial revascularization in patients with coronary artery disease and oncopathology. The use of endovascular myocardial revascularization in cancer patients reduces the risk of developing cardiovascular complications during the oncological treatment.