Mort subite et arythmies ventriculaires: Ce qui change après l'ESC 2022

SOUFIA NACCACHE
Service de cardiologie
GHEF Marne La Vallée

28ÈME CONGRÈS CNCH
PRÉSENTIEL & DIGITAL

Déclaration de liens d'intérêt potentiels

Intervenant :Soufia NACCACHE, Jossigny

☑ Je n'ai pas de lien d'intérêt potentiel à déclarer

GHEF
Grand Hôpital de l'Est Francilien

ESC European Society of Cardiology

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ESC GUIDELINES

2022 ESC Guidelines for the management of patients with ventricular arrhythmias and the prevention of sudden cardiac death

Developed by the task force for the management of patients with ventricular arrhythmias and the prevention of sudden cardiac death of the European Society of Cardiology (ESC)

Endorsed by the Association for European Paediatric and Congenital Cardiology (AEPC)

SCD Risk stratification

SCD Risk stratification

1. Genetic testing

Dilated cardiomyopathy

Genetic testing (including at least *LMNA*, *PLN*, *RBM20*, and *FLNC* genes) is recommended in patients with DCM/HNDCM and AV conduction delay at <50 years, or who have a family history of DCM/HNDCM or SCD in a first-degree relative (at age <50 years).	I
Genetic testing (including at least *LMNA*, *PLN*, *RBM20*, and *FLNC* genes) should be considered for risk stratification in patients with apparently sporadic DCM/HNDCM, who present at young age or with signs suspicious for an inherited aetiology.	IIa

Hypertrophic cardiomyopathy

Genetic counselling and testing are recommended in HCM patients.	I
ICD implantation should be considered in HCM patients aged 16 years or more with an intermediate 5-year risk of SCD (≥4 to <6%)[f], and with (a) significant LGE at CMR (usually ≥15% of LV mass); or (b) LVEF <50%; or (c) abnormal blood pressure response during exercise test[n]; or (d) LV apical aneurysm; or (e) presence of sarcomeric pathogenic mutation.	IIa
In idiopathic VF patients, genetic testing of genes related to channelopathy and cardiomyopathy may be considered.	IIb

SCD Risk stratification

2. Cardiac MRI : LGE

Dilated cardiomyopathy

CMR with LGE should be considered in DCM/HNDCM patients for assessing the aetiology and the risk of VA/SCD.	IIa
ICD implantation should be considered in DCM/HNDCM patients with an LVEF <50% and ≥2 risk factors (syncope, LGE on CMR, inducible SMVT at PES, pathogenic mutations in LMNA, *PLN*, *FLNC*, and *RBM20* genes).	IIa

Hypertrophic cardiomyopathy

CMR with LGE is recommended in HCM patients for diagnostic work-up.	I
ICD implantation should be considered in HCM patients aged 16 years or more with an intermediate 5-year risk of SCD (≥4 to <6%)[f], and with (a) significant LGE at CMR (usually ≥15% of LV mass); or (b) LVEF <50%; or (c) abnormal blood pressure response during exercise test[g]; or (d) LV apical aneurysm; or (e) presence of sarcomeric pathogenic mutation.	IIa

SCD Risk stratification

2. Cardiac MRI : LGE

Sarcoidosis

In patients with cardiac sarcoidosis who have an LVEF >35% but significant LGE at CMR after resolution of acute inflammation, ICD implantation should be considered.	IIa

SCD Risk stratification

3. PES

Coronary artery disease

ICD implantation should be considered in patients with CAD, LVEF ≤40% despite ≥3 months of OMT and NSVT, if they are inducible for SMVT by PES.	IIa	
In patients with syncope and previous STEMI, PES is indicated when syncope remains unexplained after non-invasive evaluation.	IIa	I

Dilated cardiomyopathy

ICD implantation should be considered in DCM/HNDCM patients with an LVEF <50% and ≥2 risk factors (syncope, LGE on CMR, inducible SMVT at PES, pathogenic mutations in LMNA, *PLN*, *FLNC*, and *RBM20* genes).	IIa

SCD Risk stratification

3. PES

ARVC

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.	IIa

Brugada Syndrome

PES may be considered in asymptomatic patients with a spontaneous type I BrS ECG.	IIb

Sarcoidosis

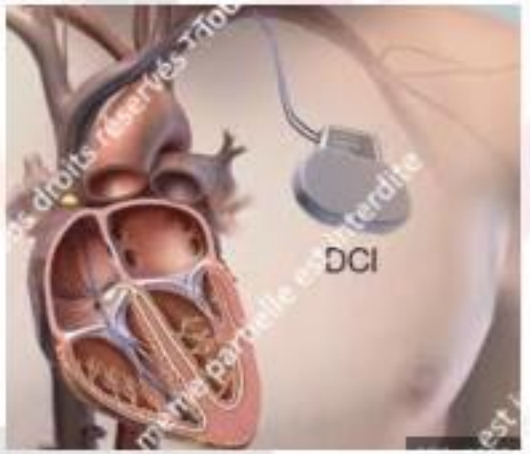
In patients with cardiac sarcoidosis who have an LVEF 35–50% and minor LGE at CMR, after resolution of acute inflammation, PES for risk stratification should be considered.	IIa
In patients with cardiac sarcoidosis, LVEF 35–50%, and inducible SMVT at PES, ICD implantation should be considered.	IIa

ICD implantation

ICD implantation

Coronary artery disease

ICD therapy should be considered in patients with CAD, NYHA class I, and LVEF ≤30% despite ≥3 months of OMT.	IIa
ICD implantation should be considered in patients with CAD, LVEF ≤40% despite ≥3 months of OMT and NSVT, if they are inducible for SMVT by PES.	IIa
In SCA survivors with coronary artery spasm, implantation of an ICD should be considered. !!!	IIa



ICD implantation

Dilated cardiomyopathy

ICD implantation should be considered in DCM/HNDCM patients with an LVEF <50% and ≥2 risk factors (syncope, LGE on CMR, inducible SMVT at PES, pathogenic mutations in LMNA, *PLN*, *FLNC*, and *RBM20* genes).	IIa
ICD implantation should be considered in patients with DCM/HNDCM and haemodynamically tolerated SMVT.	IIa

ICD implantation should be considered in patients with DCM/HNDCM, symptomatic heart failure (NYHA class II–III) and LVEF ≤35% after ≥3 months of OMT.	I	IIa

DANISH TRIAL !!!

ICD implantation

Hypertrophic cardiomyopathy

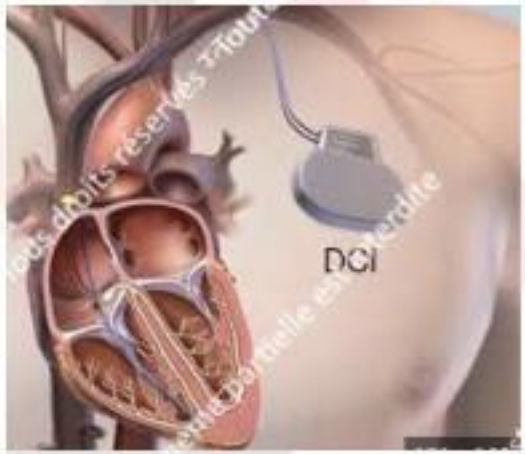
ICD implantation should be considered in HCM patients aged 16 years or more with an intermediate 5-year risk of SCD (≥4 to <6%)[f], and with (a) significant LGE at CMR (usually ≥15% of LV mass); or (b) LVEF <50%; or (c) abnormal blood pressure response during exercise test[g]; or (d) LV apical aneurysm; or (e) presence of sarcomeric pathogenic mutation.	IIa

ICD implantation may be considered in HCM patients aged 16 years or more with a low estimated 5-year risk of SCD (<4%),[f] and with (a) significant LGE at CMR (usually ≥15% of LV mass); or (b) LVEF < 50%; or (c) LV apical aneurysm.	IIb
In patients with HCM presenting with haemodynamically tolerated SMVT, ICD implantation should be considered.	IIa

ICD implantation

Myocarditis

In patients with haemodynamically tolerated SMVT occurring in the chronic phase of myocarditis, ICD implantation should be considered.	IIa
In patients with haemodynamically not-tolerated sustained VT or VF during the acute phase of myocarditis, ICD implantation before hospital discharge should be considered. !!!	IIa

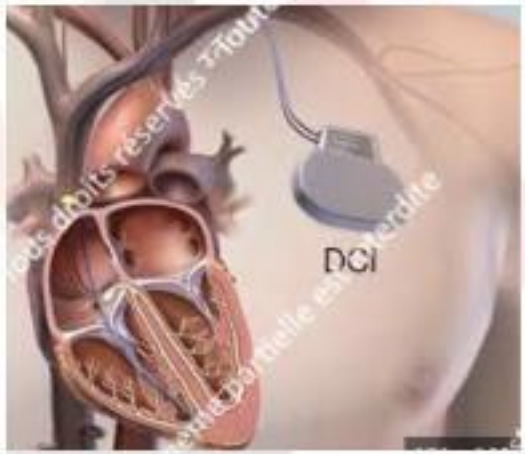


ICD implantation

Sarcoidosis

ICD implantation is recommended in patients with cardiac sarcoidosis who have an LVEF ≤35%.	IIb	I
ICD implantation is recommended in patients with cardiac sarcoidosis who (1) have documented sustained VT, or (2) aborted CA.	IIb	I
In patients with cardiac sarcoidosis who have an indication for permanent cardiac pacing related to high-degree AV block, ICD implantation should be considered, regardless of LVEF.	IIb	IIa

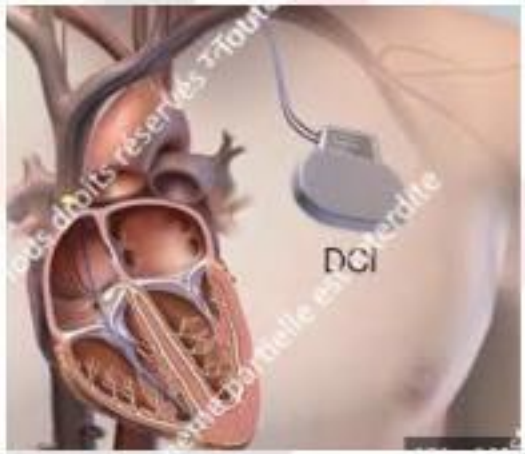
In patients with cardiac sarcoidosis who have an LVEF >35% but significant LGE at CMR after resolution of acute inflammation, ICD implantation should be considered.	IIa



ICD implantation

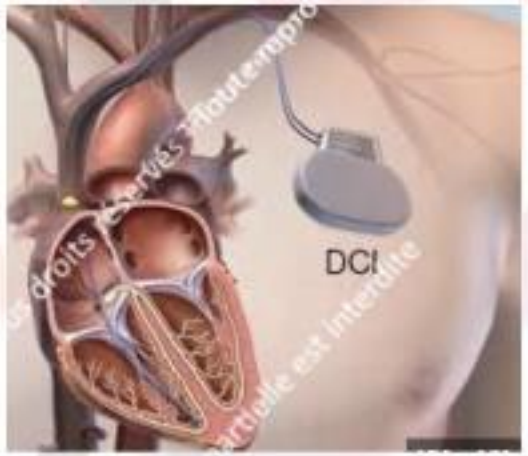
ARVC

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.	IIa



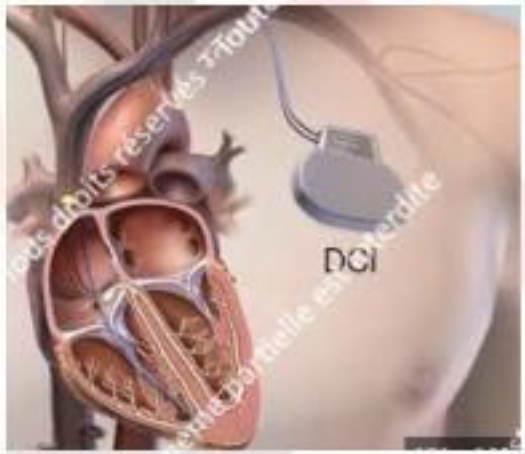
ICD implantation

The WCD should be considered for adult patients with a secondary prevention ICD indication, who are temporarily not candidates for ICD implantation.	IIa	C
The WCD may be considered in the early phase after MI in selected patients.[371,372]	IIb	B



ICD implantation

Despite a possible correctable cause for the presenting VA, the need for ICD implantation should be considered based on an individual evaluation of the risk of subsequent VA/ SCD [286,296,299]	IIa	C
In elderly patients in whom a benefit from the defibrillator is not expected due to the patient's age and comorbidities, omission of ICD implantation for primary prevention may be considered.	IIb	



Catheter Ablation

Catheter Ablation

Coronary artery disease

In patients with CAD and haemodynamically well-tolerated SMVT and LVEF ≥40%, catheter ablation in experienced centres should be considered as an alternative to ICD therapy, provided that established endpoints have been reached.[b]	**IIa**

Catheter Ablation

VT/PVC

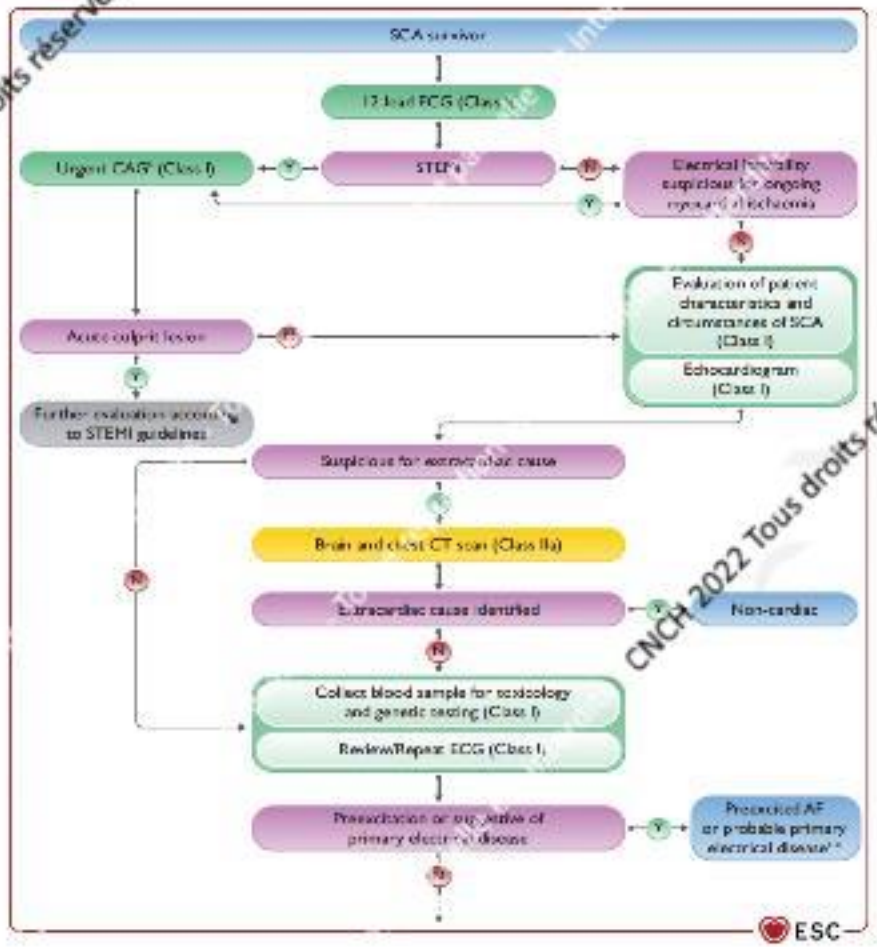
Catheter ablation as first-line treatment is recommended for symptomatic idiopathic VT/PVCs from the RVOT or the left fascicles.	I
Catheter ablation or flecainide should be considered in symptomatic patients with idiopathic VT/PVCs from an origin other than the RVOT or the left fascicles.	IIa
Catheter ablation may be considered for idiopathic VT/PVCs in asymptomatic patients with repeatedly more than 20% of PVCs per day at follow-up.	IIb
In patients with a cardiomyopathy suspected to be caused by frequent and predominately monomorphic PVCs, catheter ablation is recommended.	IIa / I

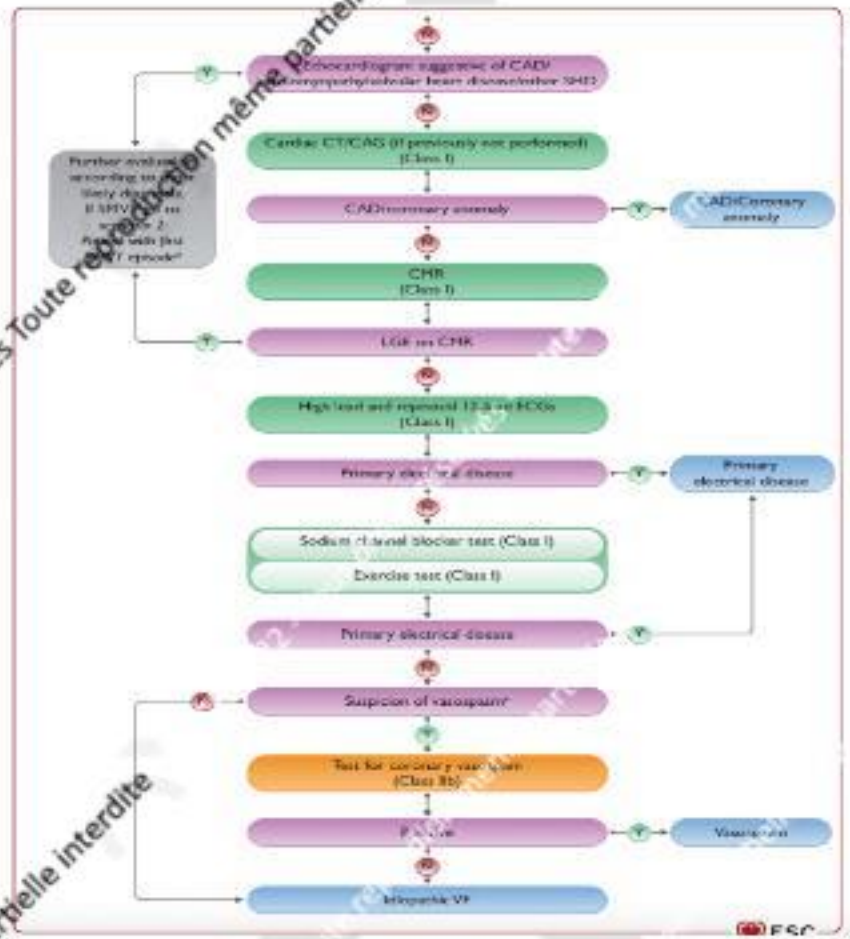
Catheter Ablation

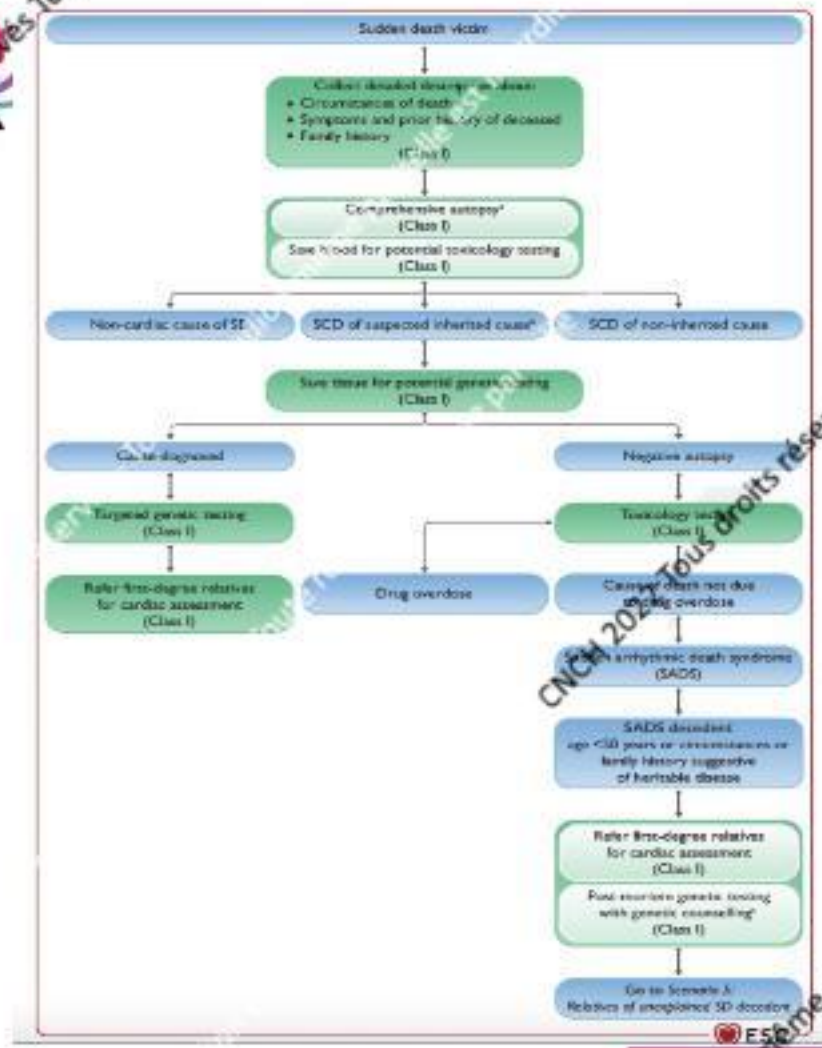
Hypertrophic cardiomyopathy

Catheter ablation in specialized centres should be considered in patients with DCM/HNDCM and recurrent, symptomatic SMVT, or ICD shocks for SMVT, in whom AADs are ineffective, contraindicated, or not tolerated.	IIb	IIa

Algorithm for SCA survivor/victim







Conclusion

- SCD risk stratification : Change the dogma → LVEF but not only !
- More ICD … Unless few exceptions*
- More ablation … for almost all VA
- Diagnosis at any cost in case of SCA

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