Practopics

Praktische topics voor de huisarts

Meld je aan met de **QR-code**

Of **klik op de link** in de Q&A rechtsboven.

Practopics

Praktische topics voor de huisarts

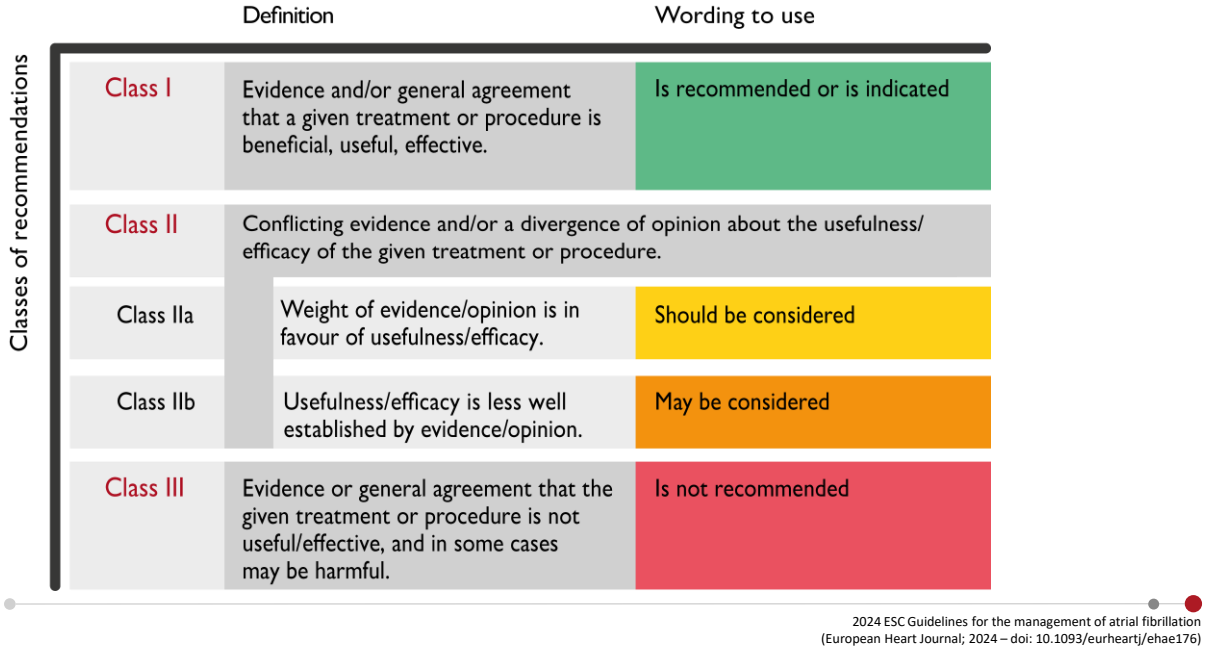
Practopics Cardiologie
ESC Richtlijnen 2024

- **Perifeer vaatlijden en Aorta pathologie**
- Voorkamerfibrillatie
- Hypertensie
- Chronisch Coronarialijden

Ann-Sofie Vanstappen
Roeland Vercauteren

ZIEKENHUIS aan de STROOM

ESC Classes of recommendations



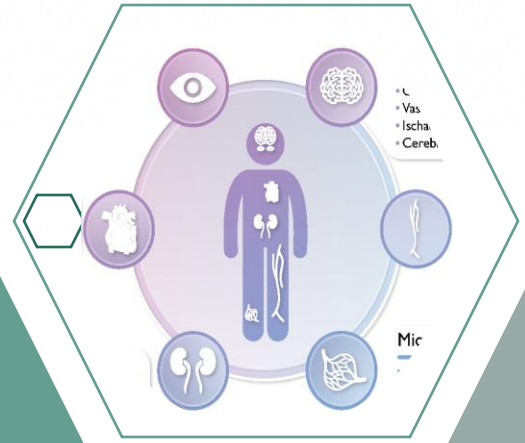
2024 ESC Guidelines for the management of atrial fibrillation
(European Heart Journal; 2024 – doi: 10.1093/eurheartj/ehae176)

ESC Levels of evidence

Level of evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of evidence C	Consensus of opinion of the experts and/or small studies, retrospective studies, registries.

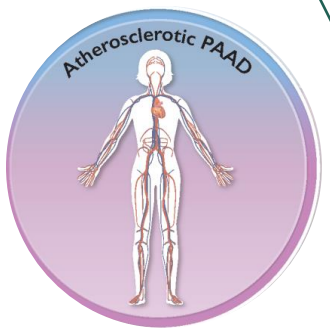
ZIEKENHUIS aan de STROOM

ESC Congress 2024 London



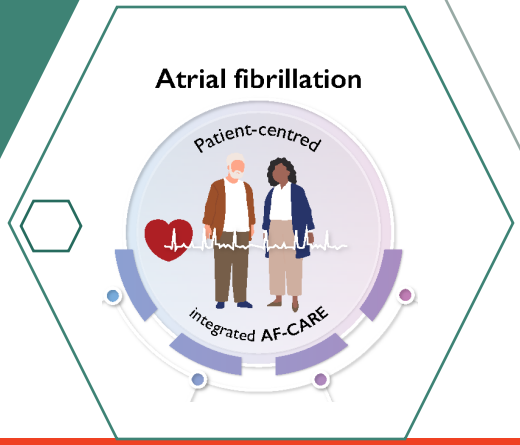
AHT

CCAD



VKF

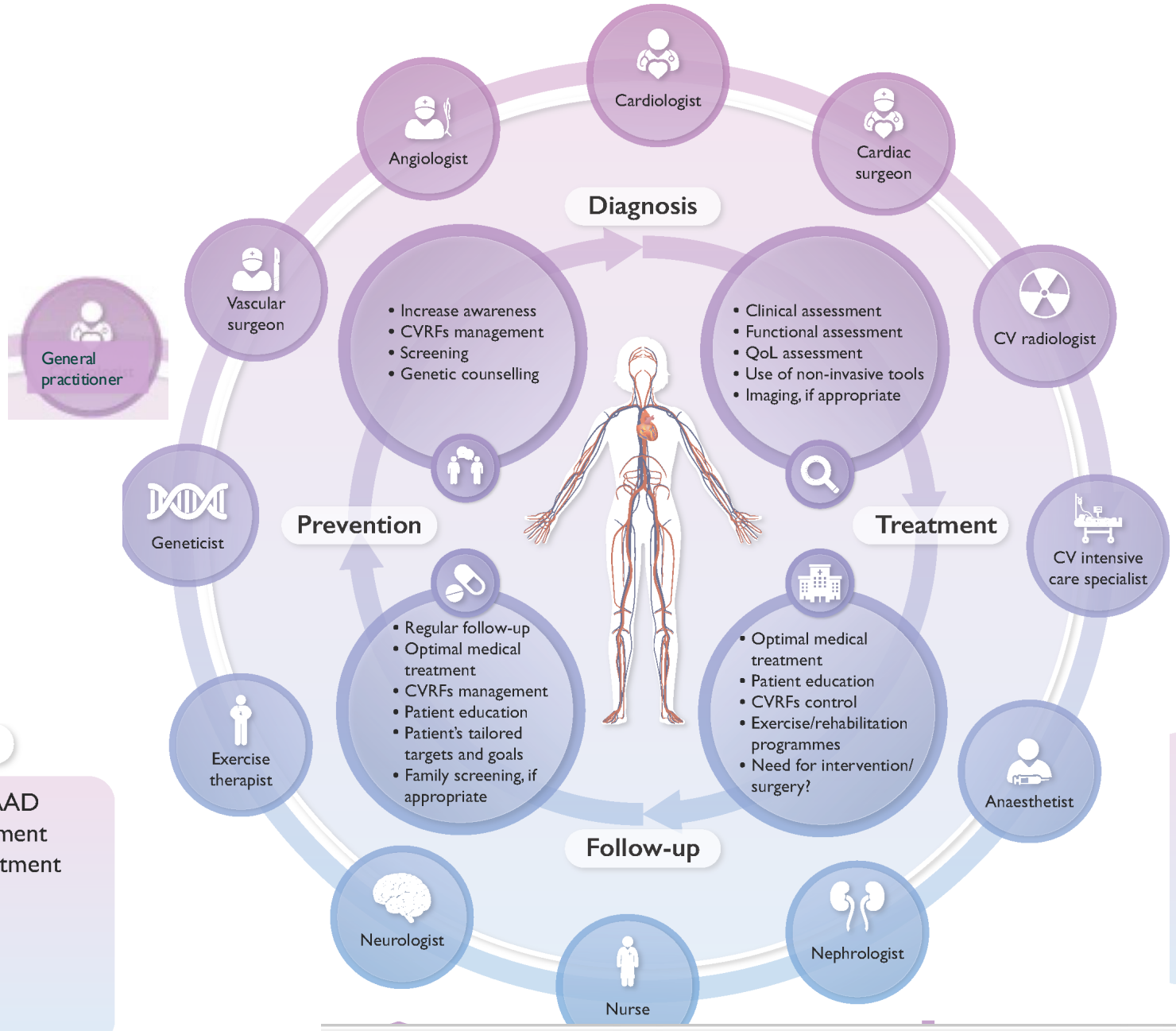
PAAD



ZIEKENHUIS aan de STROOM

Perifeer vaatlijden en aortapathologie

1. Één arterieel systeem
2. Primaire preventie en screening
3. Behandeling & secundaire preventie



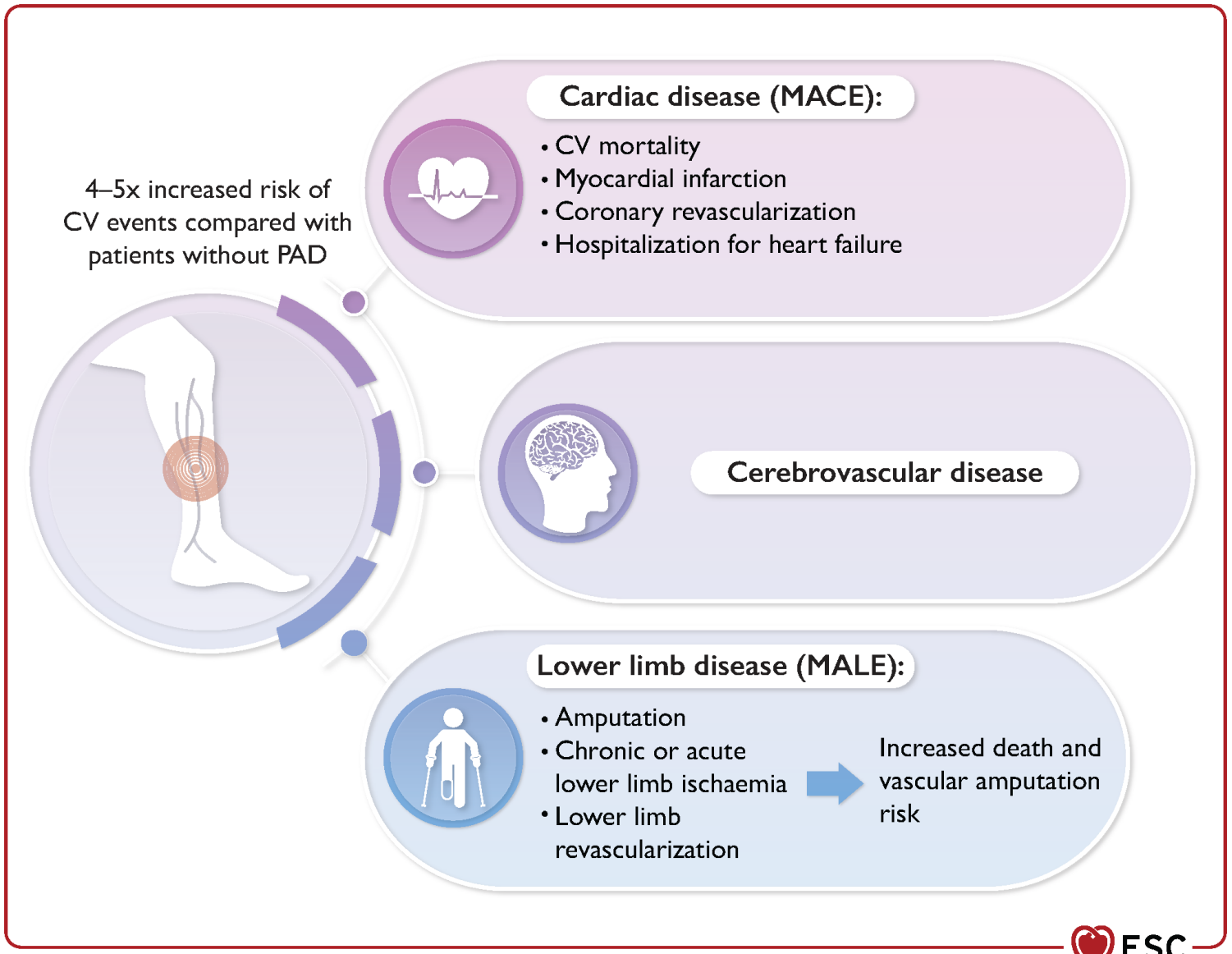
Initial steps

- Screen patients at risk of PAAD
- Enable early access to treatment
- Ensure optimal medical treatment

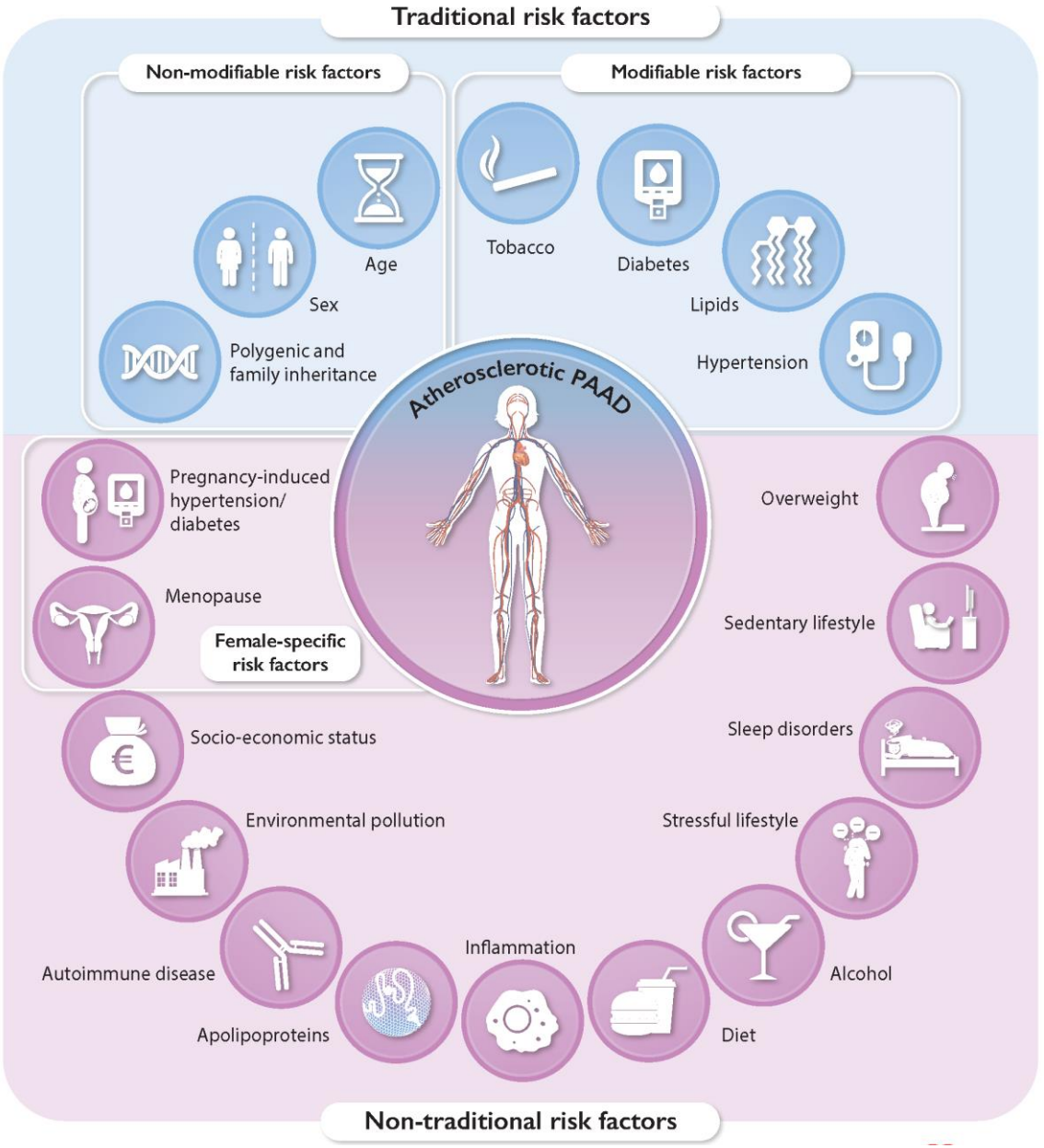
Goals

- Prevent development of peripheral and aortic atherosclerosis
- Prevent aortic dilation or lesions
- Improve patients' QoL and functioning
- Reduce risk of MACE and MALE
- Improve survival
- Reduce the risk of hospitalization
- Reduce the need for intervention/surgery

When managing PAAD, it is recommended to adopt a comprehensive approach that addresses the entirety of arterial circulation.	I	B


4–5x increased risk of CV events compared with patients without PAD
Cardiac disease (MACE):
• CV mortality
• Myocardial infarction
• Coronary revascularization
• Hospitalization for heart failure
Cerebrovascular disease
Lower limb disease (MALE):
• Amputation
• Chronic or acute lower limb ischaemia
• Lower limb revascularization
Increased death and vascular amputation risk
ESC

- Risico factoren behandelen
- Perifeer arterieel lijden
  - Enkel – Arm index
- Abdominaal aorta aneurysma screening
  - ♂ 65j en (ex-)roken
- Thoracaal arterieel lijden
  - TAAD panel & screening 1e graadsverwanten
- Carotisstenose



1 systeem – screening – secundaire preventie

ZIEKENHUIS aan de STROOM

Recommendations for abdominal aortic aneurysm screening

2017 PAD and 2014 Aortic Guidelines	Class	Level	2024 PAAD Guidelines	Class	Level
Recommendations for abdominal aortic aneurysm screening					
Screening for AAA with DUS					
Is recommended in all men >65 years of age.	I	A	Is recommended in men aged ≥65 years with a history of smoking to reduce the risk of death from ruptured AAA.	I	A
(i) May be considered in women >65 years of age with history of current/past smoking.	IIb	C	May be considered in men aged ≥75 years (irrespective of smoking history) or in women aged ≥75 years who are current smokers, hypertensive, or both.	IIb	C
(ii) Is not recommended in female non-smokers without familial history.	III	C			
Family AAA screening with DUS					
Targeted screening for AAA with ultrasound should be considered in first-degree siblings of a patient with AAA.	IIa	B	Is recommended for FDRs of patients with AAA aged ≥50, unless an acquired cause can be clearly identified.	I	C

ZIEKENHUIS aan de STROOM

Screening thoracale aneurysmata

> 60 jaar	< 60 jaar

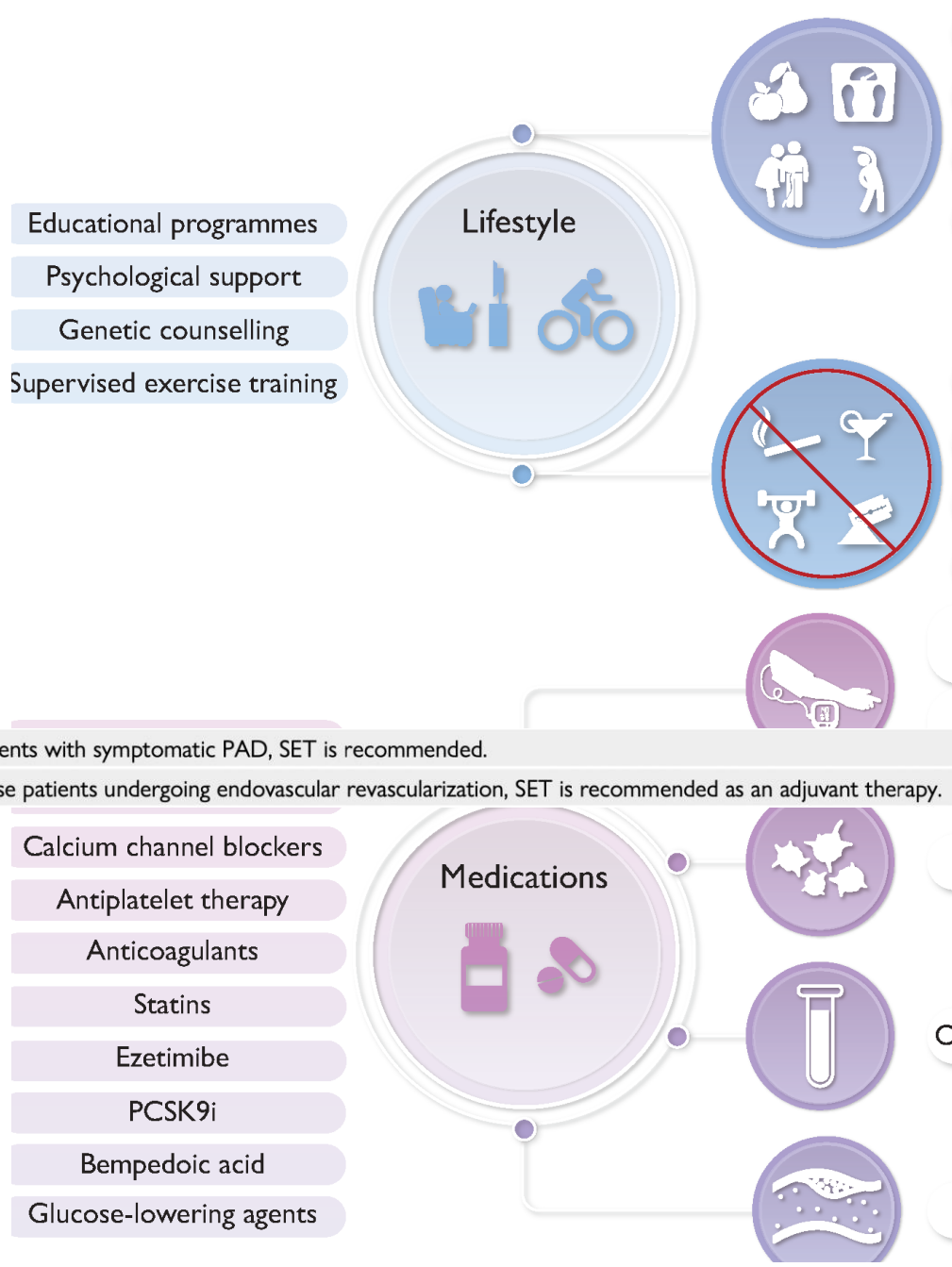
1. Geen AHT → genetische screening (= TAAD panel + TTE 1e graadsverwanten)
2. Wel AHT
  1. Geen RF: geen screening
  2. Wel RF → genetica
  1. Kenmerken van Marfan, Loeys-Dietz, Ehlers-Danlos syndroom
  2. FamVG: TAD, perifeer of intracraniele arteriele aneurysmata, plotse dood < 60j
	1. Aorta dissectie → genetica
	2. Aorta dilatatie
	  1. Geen AHT → genetica
	  2. Wel AHT
	  1. Z-score > 3 of RF → genetica
	  2. Z score <3 en geen RF: geen verdere screening

ZIEKENHUIS aan de STROOM

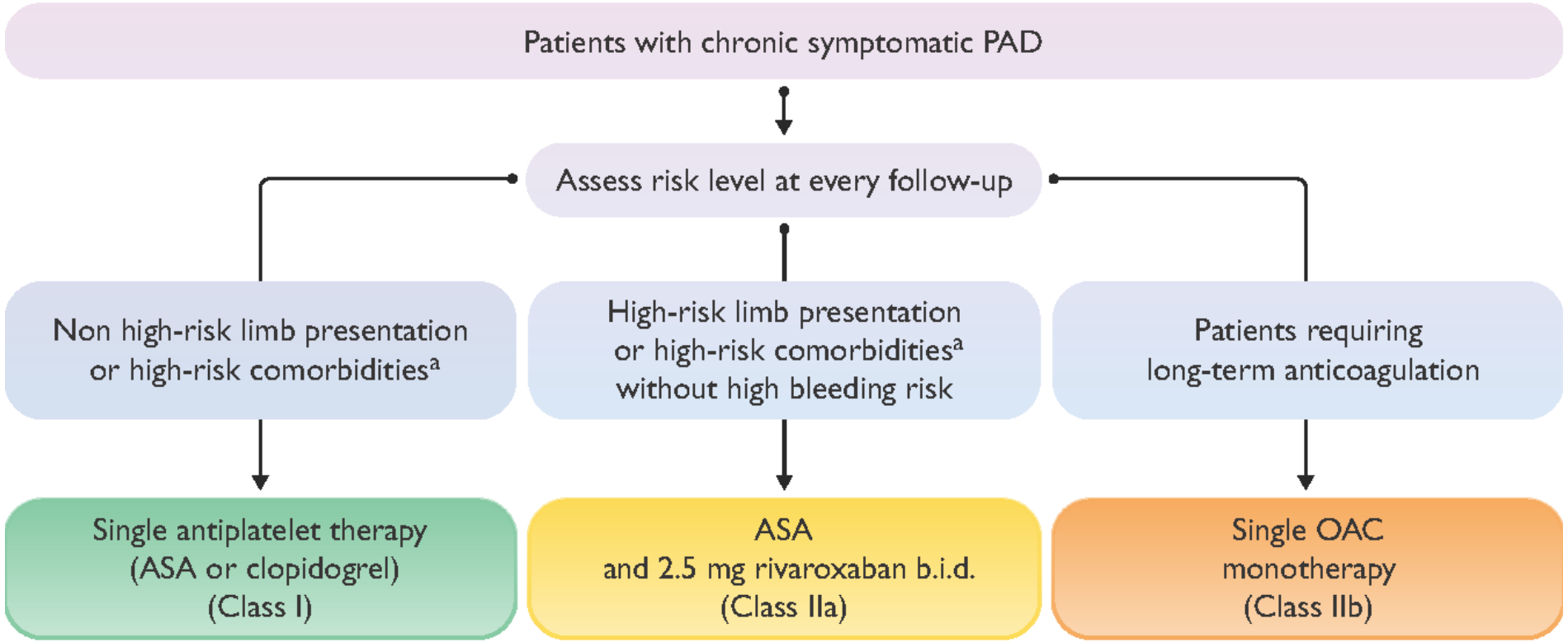
High-risk populations for carotid artery stenosis

Population	Prevalence of carotid stenosis (%)
>60 years + CVRFs (hypertension, CAD, current smoking, first-degree family history of stroke)	Two CVRFs: 14% Three CVRFs: 16% Four CVRFs: 67%
Hypertension + cardiac disease	22%
HD	•In HD patients, prevalence of carotid stenosis is high, and is associated with high peri-operative and long-term stroke or death rates •Carotid stenosis is a predictor of death in patients with long-term dialysis and aged ≥70 years at time of surgery •Lower risk if previous renal transplant.
PAD	23.2%
Severe CAD (before CABG)	•Almost 20% •Carotid bruit and T2DM: increased predictive value •Carotid stenosis = risk factors for peri-operative stroke.
Carotid bruit	31%
Previous neck irradiation	21.7% (70%–99% stenosis)

2024 ESC Guidelines for the management peripheral arterial and aortic diseases (European Heart Journal; 2024 – doi: 10.1093/eurheartj/ehae179)



ZIEKENHUIS aan de STROOM



Hoog bloedingsrisico =

Dialyse of eGFR <15ml/min

ACS < 30 dagen geleden

VG hemCVA, iCVA of TIA

Actieve bloeding

Hoog risico lidmaat =

VG amputatie, revascularisatie, CLTI

Hoog risico comorbiditeiten=

HF, DM, arterieel lijden 2 of meer gebieden, eGFR <60ml/min

1 systeem – screening – secundaire preventie

ZIEKENHUIS aan de STROOM

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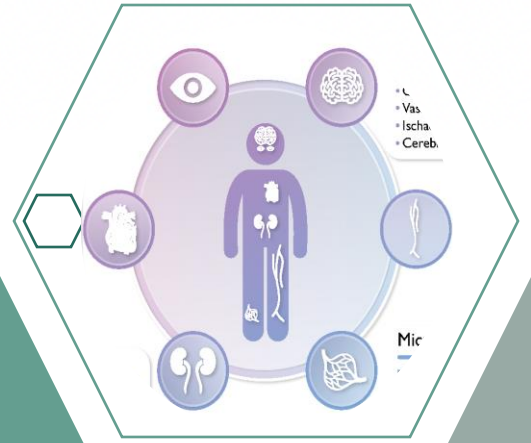
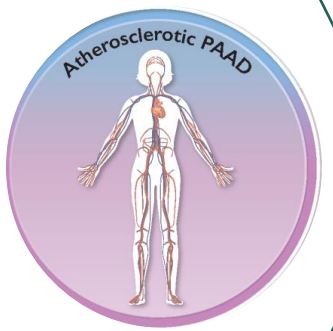
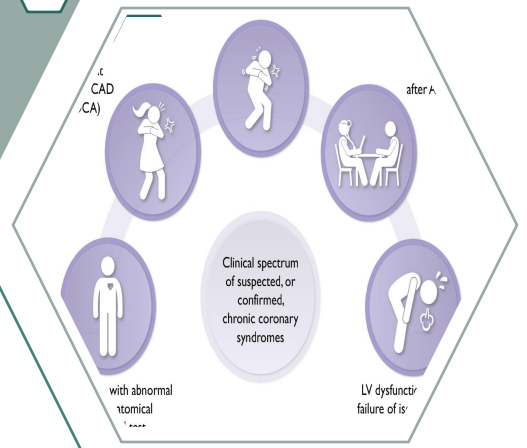


AHT

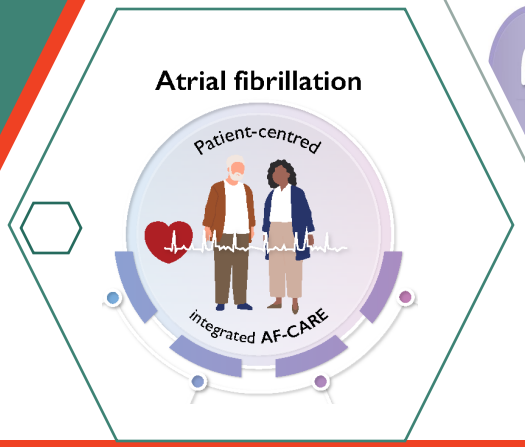


VKF

CCAD



PAAD



ZIEKENHUIS aan de STROOM

Practopics Cardiologie
ESC Richtlijnen 2024

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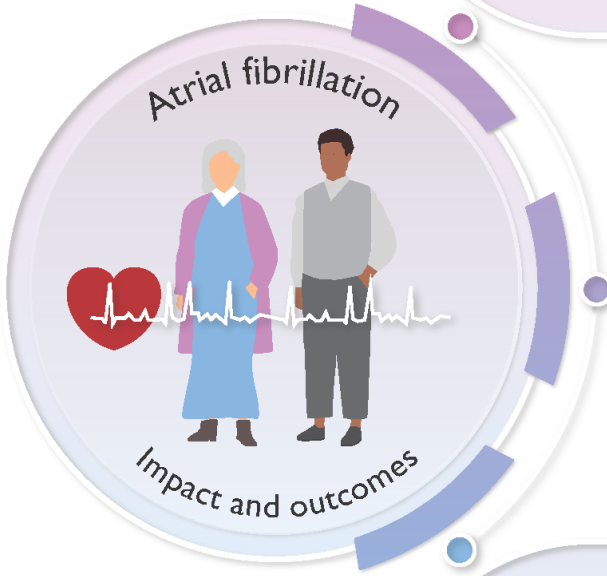
- Hypertensie
- Chronisch Coronarialijden

Ann-Sofie Vanstappen
Roeland Vercauteren

ZIEKENHUIS aan de STROOM

Voorkamerfibrillatie

1. Impact
2. Definitie
3. Diagnose
4. AF-CARE
5. In de praktijk



Patient symptoms

- Palpitations
- Shortness of breath
- Fatigue
- Chest pain
- Dizziness
- Poor exercise capacity
- Fainting (syncope)
- Anxiety
- Depressed mood
- Disordered sleep

Adverse outcomes

- Recurrent hospitalization
- Heart failure
- Ischaemic stroke
- Thromboembolism
- Cognitive decline and vascular dementia
- Depression
- Impaired quality of life
- Death

Healthcare and society

- Increasing prevalence
- High economic cost
- Impact on individuals, families and communities

Doubling of AF
2010 → 2060

Lifetime risk
1 in 5 → 1 in 3

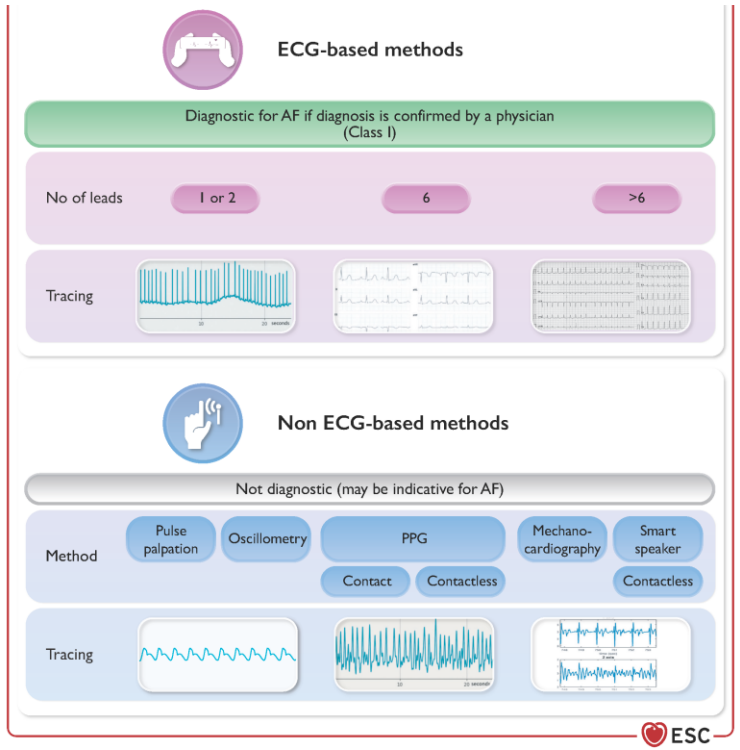
1–2% of healthcare expenditure

ZIEKENHUIS aan de STROOM

Definities

1. Eerste diagnose
    1. Onafhankelijk van symptomen, patroon of duur
2. Paroxysmale VKF
    1. Spontaan of na cardioversie sinusaal binnen de 7 dagen
    2. Self-terminating paroxysmen zijn typisch < 48u
3. Persistente VKF
    1. > 7 dagen maar het doel is ritme controle
    2. Als > 12 maanden: long-standing persistent
4. Permanente VKF
    1. Ritme controle is het doel niet meer na overleg tussen arts en patiënt

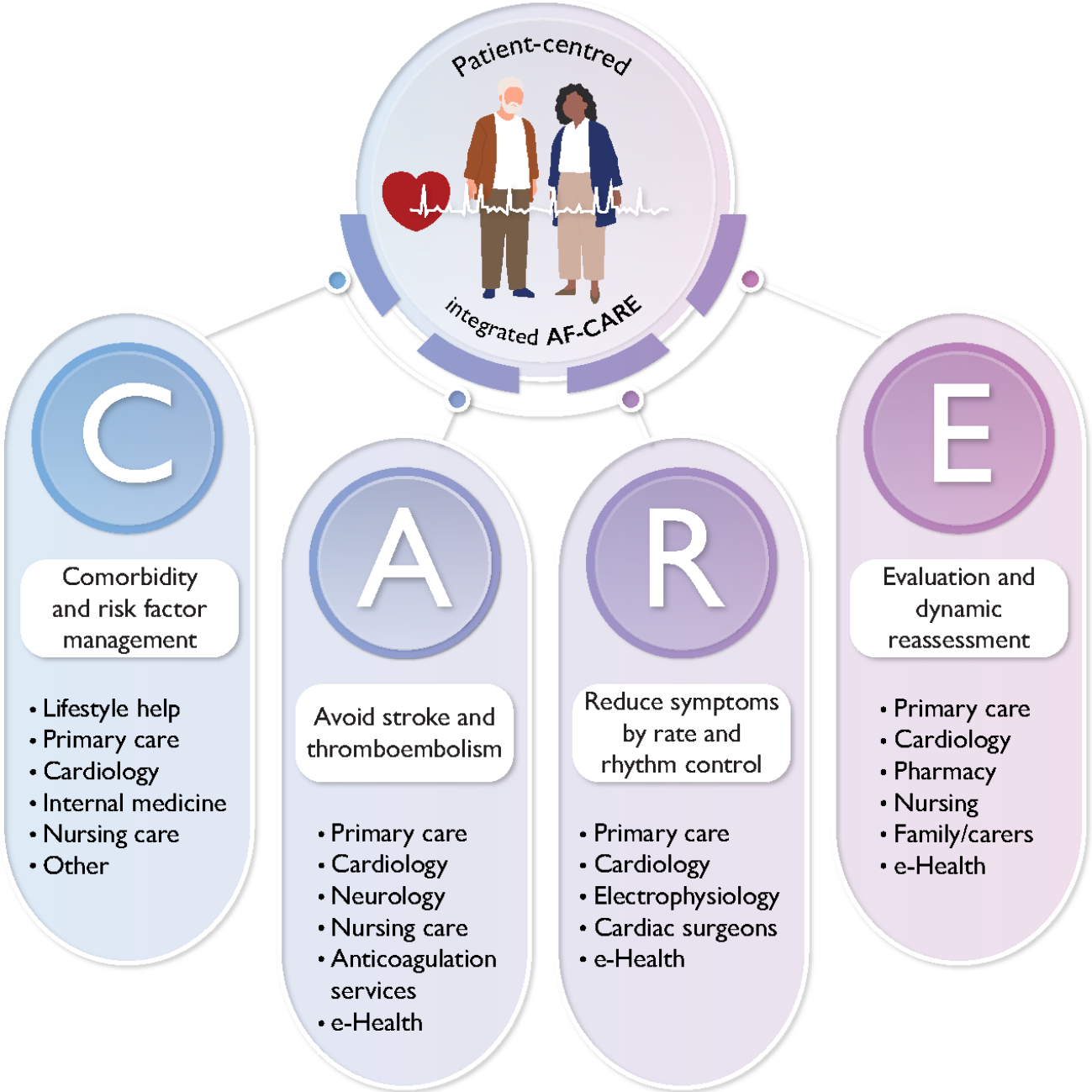
Diagnose



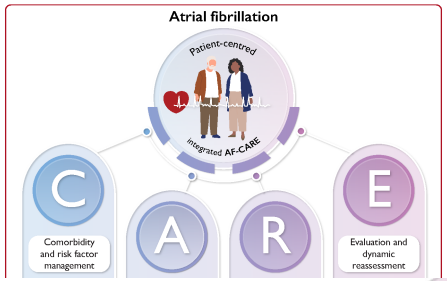
Screening approach	Population example	Setting for AF detection	Type of screening
After thromboembolic event	Patients with embolic stroke of unknown source	Initiated after index event	Invasive or non-invasive ECG Prolonged monitoring (Class I)
Ad-hoc to catch AF	Age ≥65 years, or risk of thromboembolism	At the time of routine healthcare contact	Any rhythm check, confirmed by ECG Routine heart rhythm assessment (Class I)
In patients with risk factors	Age ≥75 years, or ≥65 years plus other CHA_2DS_2-VA factors	Structured national or regional screening programmes	Population-based Non-invasive ECG (Class IIa)

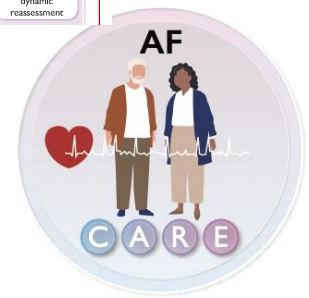
Patient informed about implications of AF detection

Atrial fibrillation



ZIEKENHUIS aan de STROOM



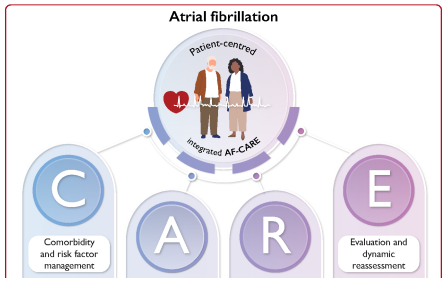


- Equality in healthcare provision (gender, ethnicity, socioeconomic) (Class I)
- Education for patients, families and healthcare professionals (Class I)
- Patient-centred AF management with a multidisciplinary approach (Class IIa)

C Comorbidity and risk factor management

Hypertension	Heart failure	Overweight or obese	Obstructive sleep apnoea	Alcohol
Blood pressure lowering treatment (Class I)	Diuretics for congestion (Class I)	Weight loss (target 10%)[a] (Class I)	Management of OSA[a] (Class IIb)	Reduce to ≤3 drinks per week (Class I)
	Appropriate HFrEF medical therapy (Class I)	Bariatric surgery if rhythm control[a] (Class IIb)		
Diabetes mellitus			**Exercise capacity**	**Other risk factors/ comorbidities**
Effective glycaemic control[a] (Class I)	SGLT2 inhibitors (Class I)		Tailored exercise programme (Class I)	Identify and manage aggressively[a] (Class I)

ZIEKENHUIS aan de STROOM



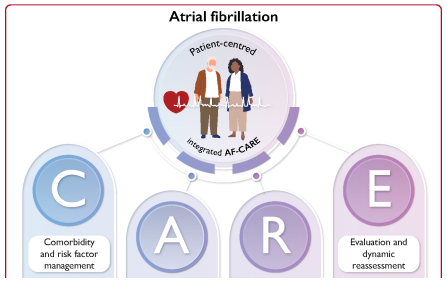
A Avoid stroke and thromboembolism

Risk of thrombo-embolism	→ Use locally-validated risk score or CHA_2DS_2-VA	→ Choice of anticoagulant	→ Assess bleeding risk	→ Prevent bleeding
Start oral anticoagulation (Class I)	OAC if CHA_2DS_2-VA score = 2 or more (Class I)	Use DOAC, except mechanical valve or mitral stenosis (Class I)	Assess and manage all modifiable risk factors for bleeding (Class I)	Do not combine antiplatelets and OAC for stroke prevention (Class III)
Temporal pattern of AF not relevant (Class III)	OAC if CHA_2DS_2-VA score = 1 (Class IIa)	If VKA: Target INR 2.0–3.0; (Class I) >70% INR range; (Class IIa) or switch to DOAC (Class I)	Do not use risk scores to withhold anticoagulation (Class III)	Avoid antiplatelets beyond 12 months in OAC treated CCS/PVD (Class III)
Antiplatelet therapy not an alternative (Class III)				

Updated definitions for the CHA_2DS_2-VA score

CHA_2DS_2-VA component		Definition and comments	Points awarded
C	Chronic heart failure	Symptoms and signs of heart failure (irrespective of LVEF, thus including HFpEF, HFmrEF, and HFrEF), or the presence of asymptomatic LVEF ≤40%.	1
H	Hypertension	Resting blood pressure >140/90 mmHg on at least two occasions, or current antihypertensive treatment. The optimal BP target associated with lowest risk of major cardiovascular events is 120–129/70–79 mmHg (or keep as low as reasonably achievable).	1
A	Age 75 years or above	Age is an independent determinant of ischaemic stroke risk. Age-related risk is a continuum, but for reasons of practicality, two points are given for age ≥75 years.	2
D	Diabetes mellitus	Diabetes mellitus (type 1 or type 2), as defined by currently accepted criteria, or treatment with glucose lowering therapy.	1
S	Prior stroke, TIA, or arterial thromboembolism	Previous thromboembolism is associated with highly elevated risk of recurrence and therefore weighted 2 points.	2
V	Vascular disease	Coronary artery disease, including prior myocardial infarction, angina, history of coronary revascularization (surgical or percutaneous), and significant CAD on angiography or cardiac imaging OR Peripheral vascular disease, including: intermittent claudication, previous revascularization for PVD, percutaneous or surgical intervention on the abdominal aorta, and complex aortic plaque on imaging (defined as features of mobility, ulceration, pedunculation, or thickness ≥4 mm).	1
A	Age 65–74 years	1 point is given for age between 65 and 74 years.	1

A CHA_2DS_2-VA score of 2 or more is recommended as an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation.	I	C
A CHA_2DS_2-VA score of 1 should be considered an indicator of elevated thromboembolic risk for decisions on initiating oral anticoagulation.	IIa	C



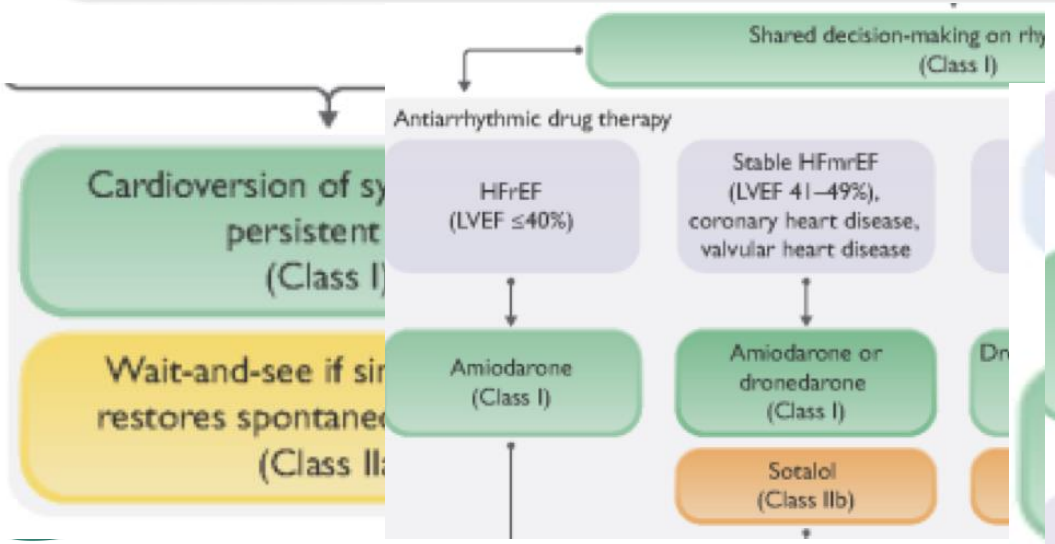
Reduce symptoms by rate and rhythm control

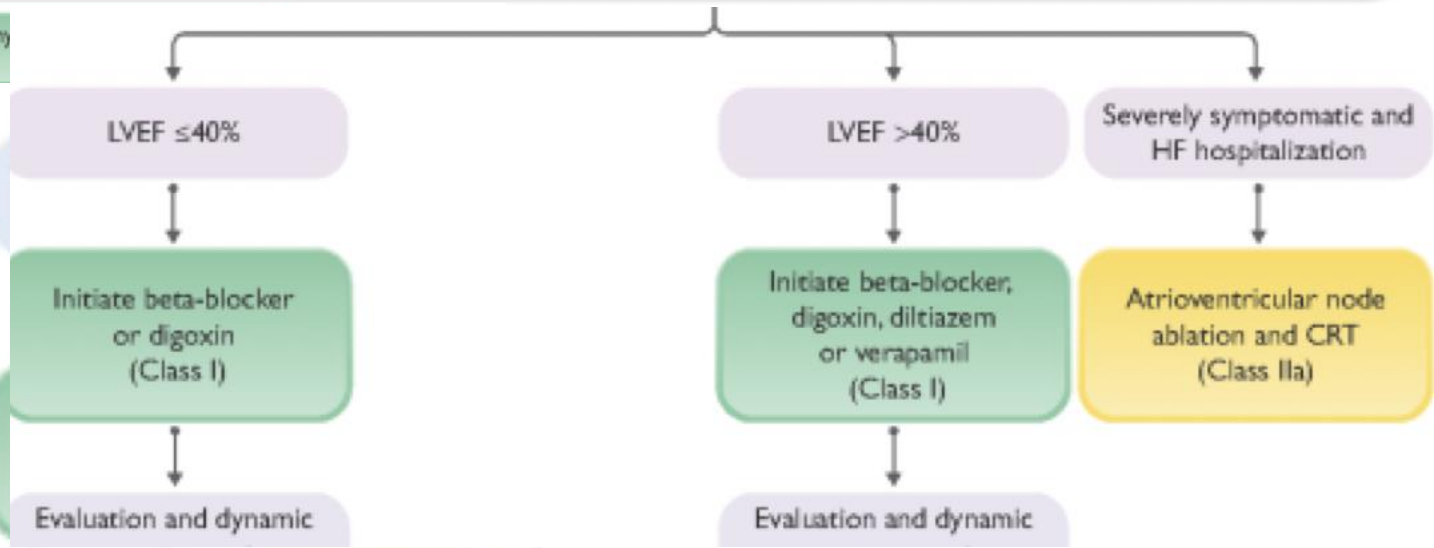
See patient pathways for:

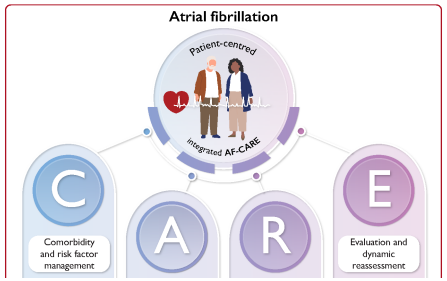
First-diagnosed AF | Paroxysmal AF | Persistent AF | Permanent AF

Consider:

Rate control drugs | Cardioversion | Antiarrhythmic drugs | Catheter ablation | Endoscopic/hybrid ablation | Surgical ablation | Ablate and pace







Evaluation and dynamic reassessment

Re-evaluate when AF episodes or non-AF admissions

Regular re-evaluation: 6 months after presentation, and then at least annually or based on clinical need

ECG, blood tests, cardiac imaging, ambulatory ECG, other imaging as needed

Assess new and existing risk factors and comorbidities (Class I)

Stratify risk for stroke and thromboembolism (Class I)

Check impact of AF symptoms before and after treatment (Class I)

Assess and manage modifiable bleeding risk factors (Class I)

Continue OAC despite rhythm control if risk of thromboembolism (Class I)

ZIEKENHUIS aan de STROOM

Casus 1: Suzy 72 jaar

Ex-roker, AHT

permanente VKF

Surgical closure of the left atrial appendage is recommended as an adjunct to oral anticoagulation in patients with AF undergoing cardiac surgery to prevent ischaemic stroke and thromboembolism.	I	B
Percutaneous LAA occlusion may be considered in patients with AF and contraindications for long-term anticoagulant treatment to prevent ischaemic stroke and thromboembolism.[372,376,386,387]	IIb	C

Ischemisch CVA onder antico

OF

Hoog bloedingsrisico vb recidiverende gastro-intestinale bloedingen

OF

Electieve cardiale heelkunde

→ Linkerhartoor sluiten

ZIEKENHUIS aan de STROOM

Casus 2: Jef: 69 jaar

Ex-roker, hyperthyroïdie

Bloeddruk meter geeft Afib

Perifeer oedeem

1. Diagnose

Confirmation by an electrocardiogram (12-lead, multiple, or single leads) is recommended to establish the diagnosis of clinical AF and commence risk stratification and treatment.	I	A

2. C – A – R – E

Sodium-glucose cotransporter-2 inhibitors are recommended for patients with HF and AF regardless of left ventricular ejection fraction to reduce the risk of HF hospitalization and cardiovascular death.	I	A
Trigger-induced AF—*Section 9.5*		
Long-term oral anticoagulation should be considered in suitable patients with trigger-induced AF at elevated thromboembolic risk to prevent ischaemic stroke and systemic thromboembolism.	IIa	C

ZIEKENHUIS aan de STROOM

Continuation of oral anticoagulation is recommended after AF ablation according to the patient's CHA_2DS_2-VA score, and not the perceived success of the ablation procedure, to prevent ischaemic stroke and thromboembolism.	I	C

Succesvolle ablatie

6 maanden later wil graag stoppen met antico

After uncomplicated PCI, early cessation (≤1 week) of aspirin and continuation of an oral anticoagulant and a $P2Y_{12}$ inhibitor (preferably clopidogrel) for up to 6 months is recommended to avoid major bleeding, if ischaemic risk is low.	I	A

1 jaar later PCI in kader van onstabiele angor

Wat nu met antico?

AFIB MATTERS
ATRIAL FIBRILLATION

https://www.afibmatters.org

StopAfib.org

ESC
European Society of Cardiology

GET IT ON Google play

Available on the App Store

ESC CVD Risk Calculation

U-Prevent

https://u-prevent.com/

ZIEKENHUIS aan de STROOM

Education directed to patients, family members, caregivers, and healthcare professionals is recommended to optimize shared decision-making, facilitating open discussion of both the benefit and risk associated with each treatment option.	I	C

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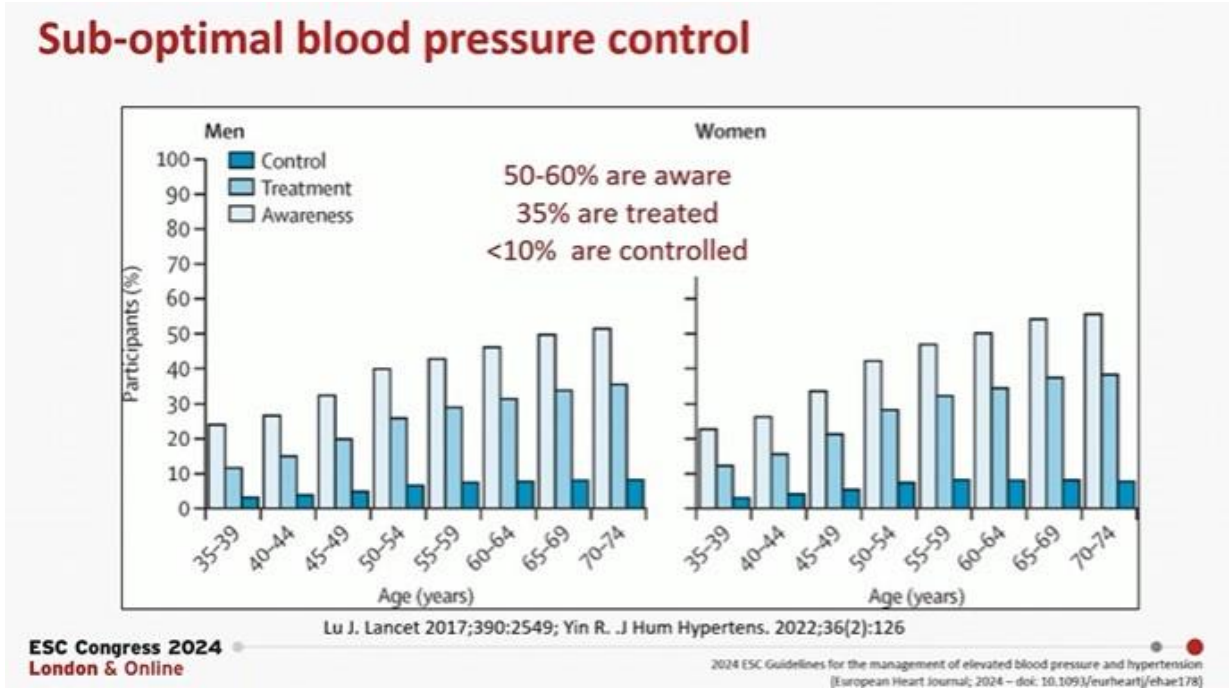
ZIEKENHUIS aan de STROOM

Hypertensie



ESC European Society of Cardiology
European Heart Journal (2024) **00**, 1–107
https://doi.org/10.1093/eurheartj/ehae178
ESC GUIDELINES

2024 ESC Guidelines for the management of elevated blood pressure and hypertension

Developed by the task force on the management of elevated blood pressure and hypertension of the European Society of Cardiology (ESC) and *endorsed by the European Society of Endocrinology (ESE) and the European Stroke Organisation (ESO)*

Authors/Task Force Members: John William McEvoy *†, (Chairperson) (Ireland), Cian P. McCarthy ‡, (Task Force Co-ordinator) (United States of America), Rosa Maria Bruno ‡, (Task Force Co-ordinator) (France), Sofie Brouwers (Belgium), Michelle D. Canavan (Ireland), Claudio Ceconi (Italy), Ruxandra Maria Christodorescu (Romania), Stella S. Daskalopoulou (Canada), Charles J. Ferro [1] (United Kingdom), Eva Gerdts (Norway), Henner Hanssen (Switzerland), Julie Harris (United Kingdom), Lucas Lauder (Switzerland/Germany), Richard J. McManus (United Kingdom), Gerard J. Molloy (Ireland), Kazem Rahimi (United Kingdom), Vera Regitz-Zagrosek (Germany), Gian Paolo Rossi [2] (Italy), Else Charlotte Sandset [3] (Norway), Bart Scheenaerts (Belgium), Jan A. Staessen (Belgium), Izabella Uchmanowicz (Poland), Maurizio Volterrani (Italy), Rhian M. Touyz *†, (Chairperson) (Canada), and ESC Scientific Document Group

ZIEKENHUIS aan de STROOM

Hypertensie

1. Verhoogde bloeddruk en Hypertensie
2. Wie behandelen
3. Streefbloeddruk
4. Levensstijl maatregelen
5. Medicatie
6. Screening en opvolging

1. Verhoogde bloeddruk en Hypertensie

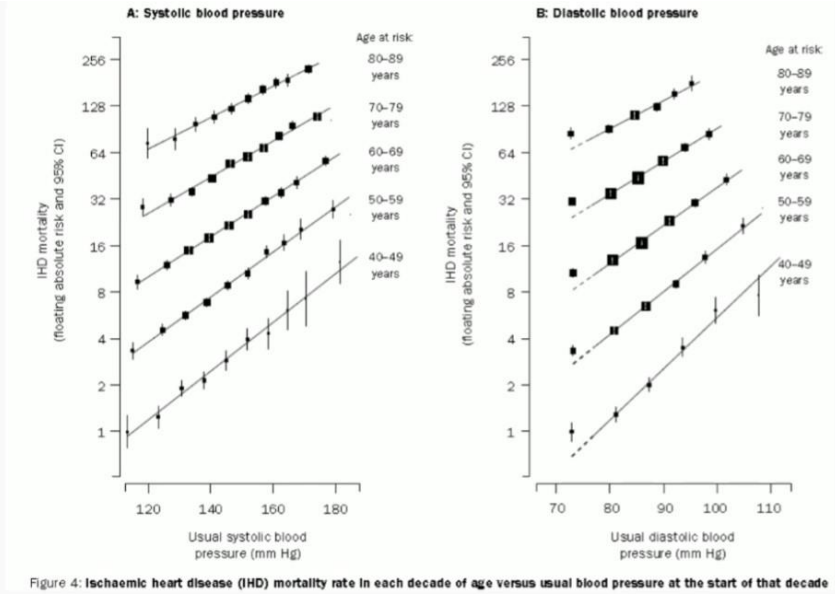
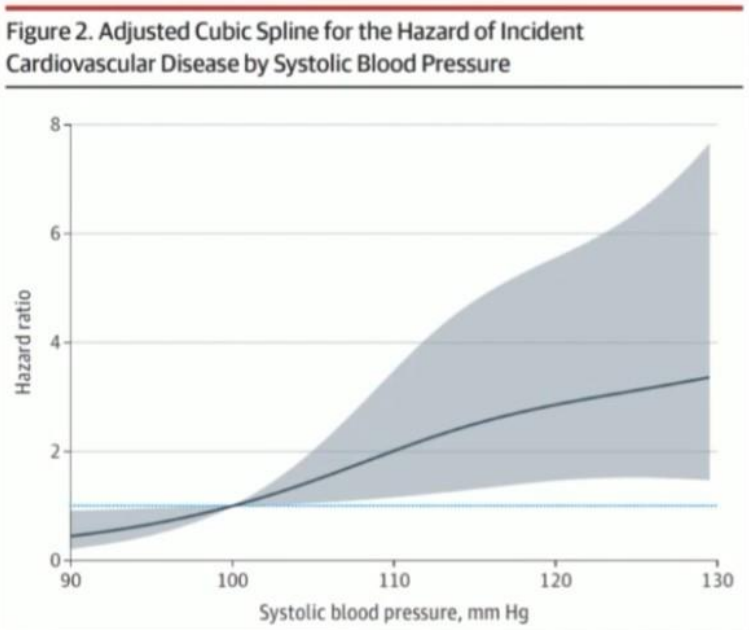


Figure 4: **Ischaemic heart disease (IHD) mortality rate in each decade of age versus usual blood pressure at the start of that decade**

Prospective Studies Collaboration (1 million)
Lancet 2002; 360: 1903–13



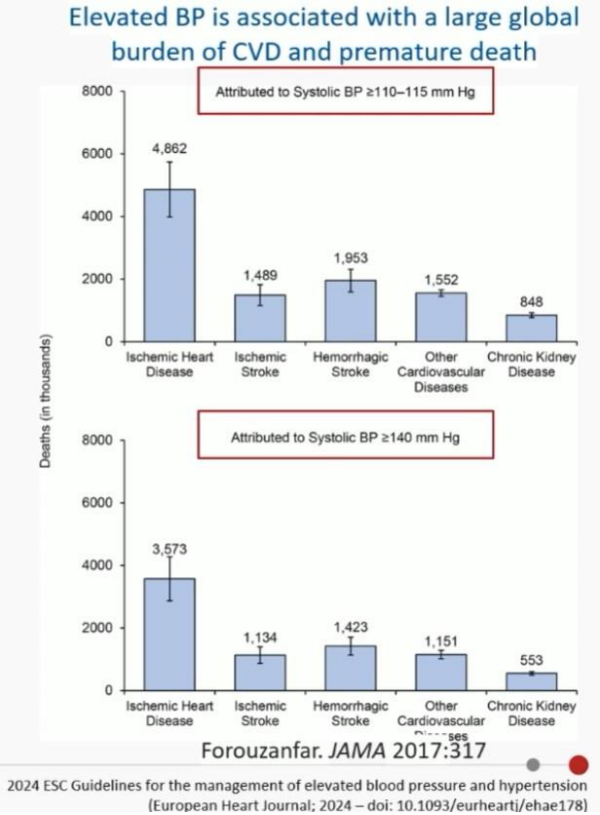
Seamus Whelton, et al. (N=1457)
JAMA Cardiol 2020; 5: 1011-1018

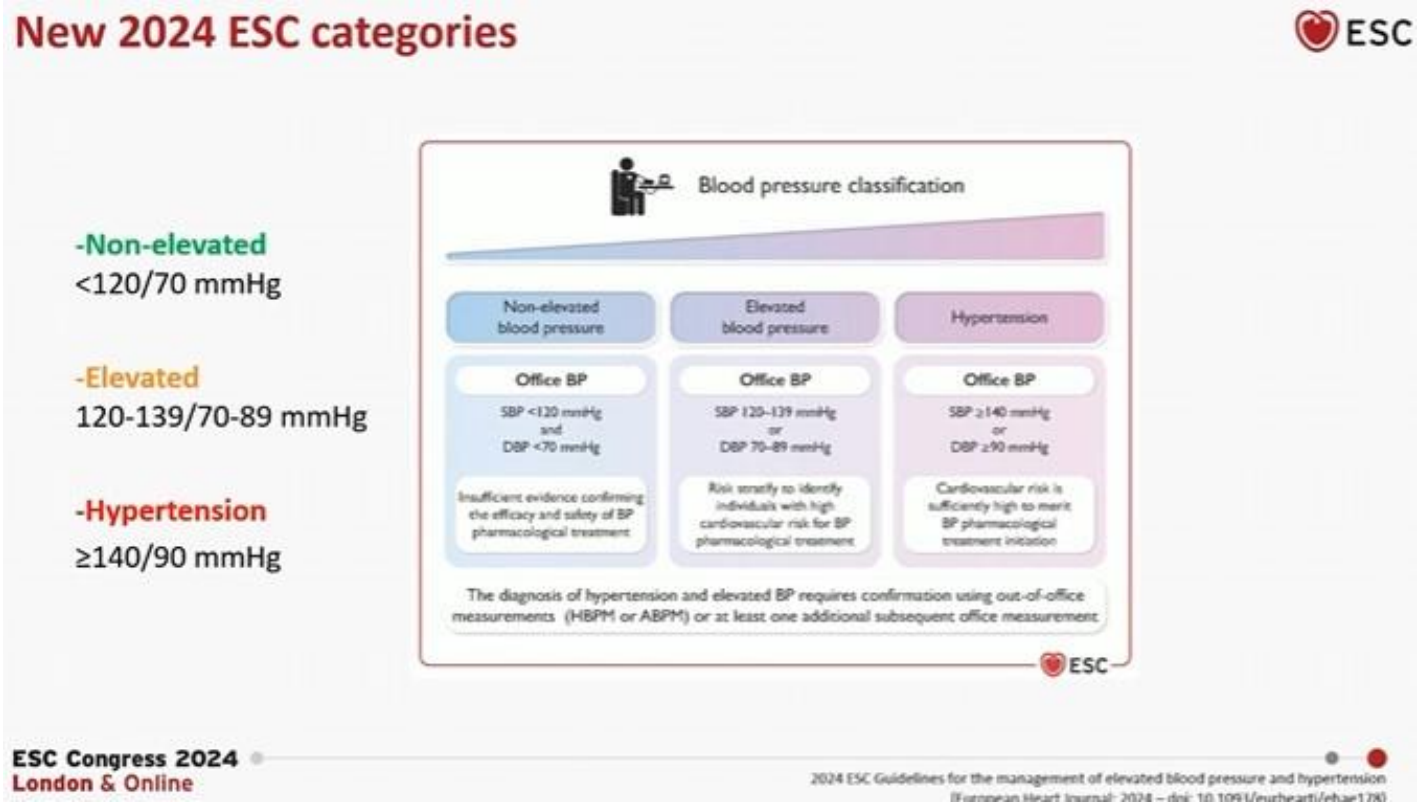
ESC Congress 2024
London & Online

2024 ESC Guidelines for the management of elevated blood pressure and hypertension
(European Heart Journal; 2024 – doi: 10.1093/eurheartj/ehae178)

ZIEKENHUIS aan de STROOM

1. Verhoogde bloeddruk en Hypertensie





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2. Wie behandelen

- >140 mmHg = Hypertensie
  - altijd behandelen

2. Wie behandelen

- 120-139 mmHg = verhoogde bloeddruk
  - secundaire preventie (na coronair, cerebraal of perifeer event)
  - eGFR < 60 of proteïnurie
  - DM (tenzij <60j en laag risico)
  - AHT met orgaanschade
  - familiale hypercholesterolemie
  - SCORE risico >10%
  - SCORE risico 5-10% met:
    - Na zwangerschapsverwikkelingen (hypertensie, diabetes, pre-eclampsie…)
    - Zeer hoog familiaal risico, auto-immuunziekte, HIV, psychiatrische patiënten…
    - Hoge CAC-score, plaque op echo/duplex…

3. Streefbloeddruk

- Systolisch 120-129 mmHg
- ((Diastolisch 70-79 mmHg))
- Minder streng (“ALARA”) bij:
  - orthostatische hypotensie
  - >85j
  - hoge frailty
  - levensverwachting <3j

4. Levensstijl maatregelen

- Minder sedentair: stappen, trap i.p.v. lift…
- Voeding:
  - zoutarm (idealiter <5g NaCl)
  - vetarm, "Mediterraans"
  - vermageren tot BMI <25
  - alcohol beperken
- Sport:
  - 150 min per week matige intensiteit
  - of 75 min per week hoge intensiteit
- Voeding:
  - Kalium rijk zout (bv. 25% KCl)
  - koffie en thee niet vermijden
  - energiedrank en frisdrank wel vermijden
- "Turnen" 2-3 keer per week
  - isometric resistance training: bv. plank, muurzitten…
  - dynamic resistance training: bv. squat, push-up, sit-up…

- Hypertensie: levensstijlmaatregelen + meteen medicatie
- Verhoogde bloeddruk: 3 maanden levensstijlmaatregelen, dan medicatie

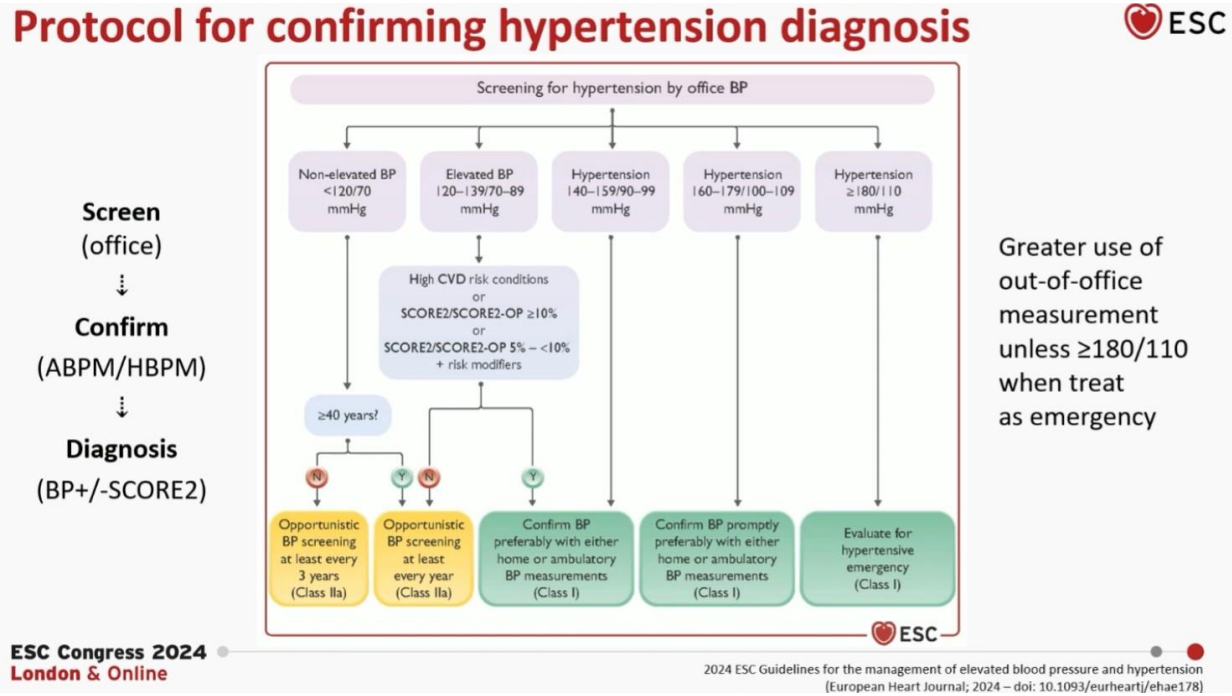
5. Medicatie

- 1e lijn:
  - lage dosis ACE-i/ARB + Ca antagonist
  - lage dosis ACE-i/ARB + Thiazide
- 2e lijn: lage dosis ACE-i/ARB + Ca antagonist + Thiazide
- 3e lijn: maximale dosis ACE-i/ARB + Ca antagonist + Thiazide
- 4e lijn: + Spironolacton
- 5e lijn: + Bèta blokker
- 6e lijn:
  - + Centraal werkend (bv. Moxonidine)
  - + Alfa blokker
  - + Hydralazine

5. Medicatie

- Tijdstip medicatie: wanneer het best past voor de pt.
- Specifieke indicaties:
  - ACE-i/ARB:
    - hartfalen (HFrEF en HFmrEF)
    - hartinfarct
    - kleplijden (aortaklep, mitralisklep)
    - proteïnurie
  - Ca antagonist:
    - angor
    - zwarte patiënten
  - Bèta blokker:
    - ritmestoornis
    - hartinfarct
    - hartfalen (HFrEF)
    - angor

6. Screening en opvolging



- Opportunistische screening:
  - >40j: 1 x per jaar
  - <40j: 1 x per 3 jaar
- Voorkeur voor:
  - zelfmeting thuis (2x/d, 3-7d)
  - 24u BD-meting
  - (Opgelet: automatische BD-meters zijn vaak niet gevalideerd bij VKF, overweeg manuele meting)
- Opvolging:
  - Aanpassen therapie: controle na 1 tot 3 maanden
  - Doel bereikt: controle 1 x per jaar

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Practopics Cardiologie
ESC Richtlijnen 2024

- Perifeer vaatlijden en Aorta pathologie
- Voorkamerfibrillatie
- Hypertensie
- Chronisch Coronarialijden

Ann-Sofie Vanstappen
Roeland Vercauteren

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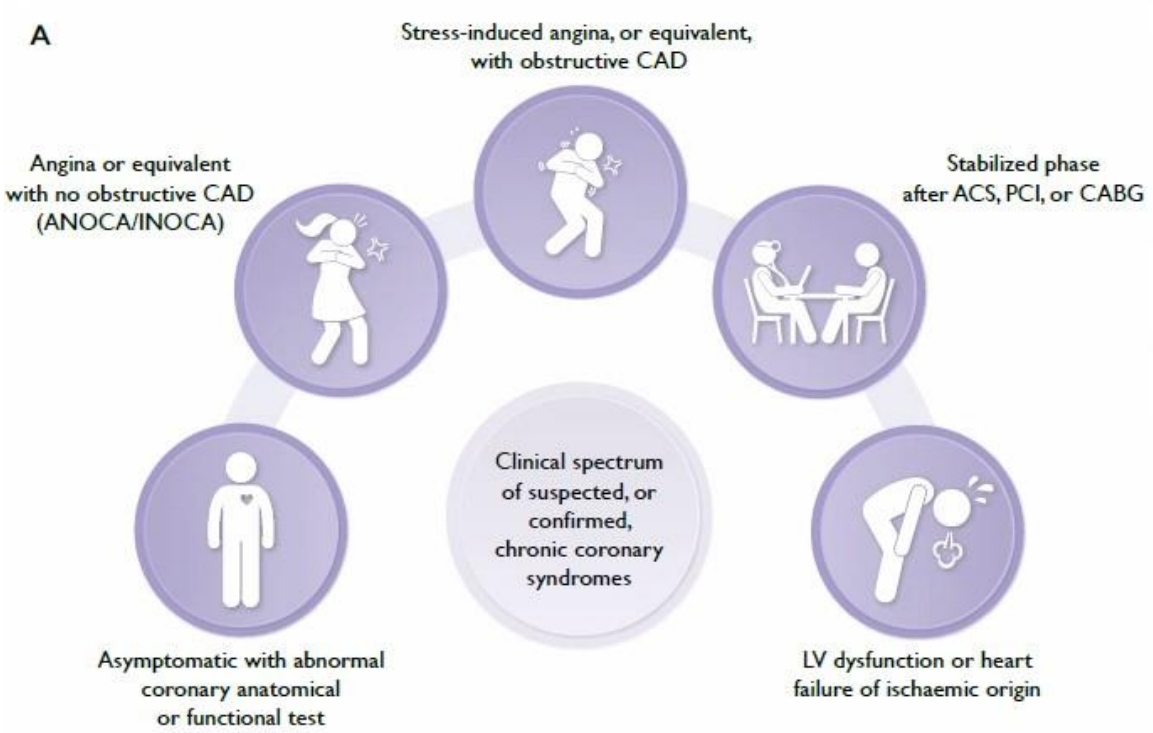
Chronisch Coronarialijden (CCS)



ESC European Society of Cardiology
European Heart Journal (2024) 00, 1–123
https://doi.org/10.1093/eurheartj/ehae177
ESC GUIDELINES

2024 ESC Guidelines for the management of chronic coronary syndromes

Developed by the task force for the management of chronic coronary syndromes of the European Society of Cardiology (ESC)

Endorsed by the European Association for Cardio-Thoracic Surgery (EACTS)

Authors/Task Force Members: Christiaan Vrints *†, (Chairperson) (Belgium), Felicita Andreotti *†, (Chairperson) (Italy), Konstantinos C. Koskinas‡, (Task Force Co-ordinator) (Switzerland), Xavier Rossello ‡, (Task Force Co-ordinator) (Spain), Marianna Adamo (Italy), James Ainslie (United Kingdom), Adrian Paul Banning (United Kingdom), Andrzej Budaj (Poland), Ronny R. Buechel (Switzerland), Giovanni Alfonso Chiariello (Italy), Alaide Chieffo (Italy), Ruxandra Maria Christodorescu (Romania), Christi Deaton (United Kingdom), Torsten Doenst [1] (Germany), Hywel W. Jones (United Kingdom), Vijay Kunadian (United Kingdom), Julinda Mehilli (Germany), Milan Milojevic [1] (Serbia), Jan J. Piek (Netherlands), Francesca Pugliese (United Kingdom), Andrea Rubboli (Italy), Anne Grete Semb (Norway), Roxy Senior (United Kingdom), Jurrien M. ten Berg (Netherlands), Eric Van Belle (France), Emeline M. Van Craenenbroeck (Belgium), Rafael Vidal-Perez (Spain), Simon Winther (Denmark), and ESC Scientific Document Group

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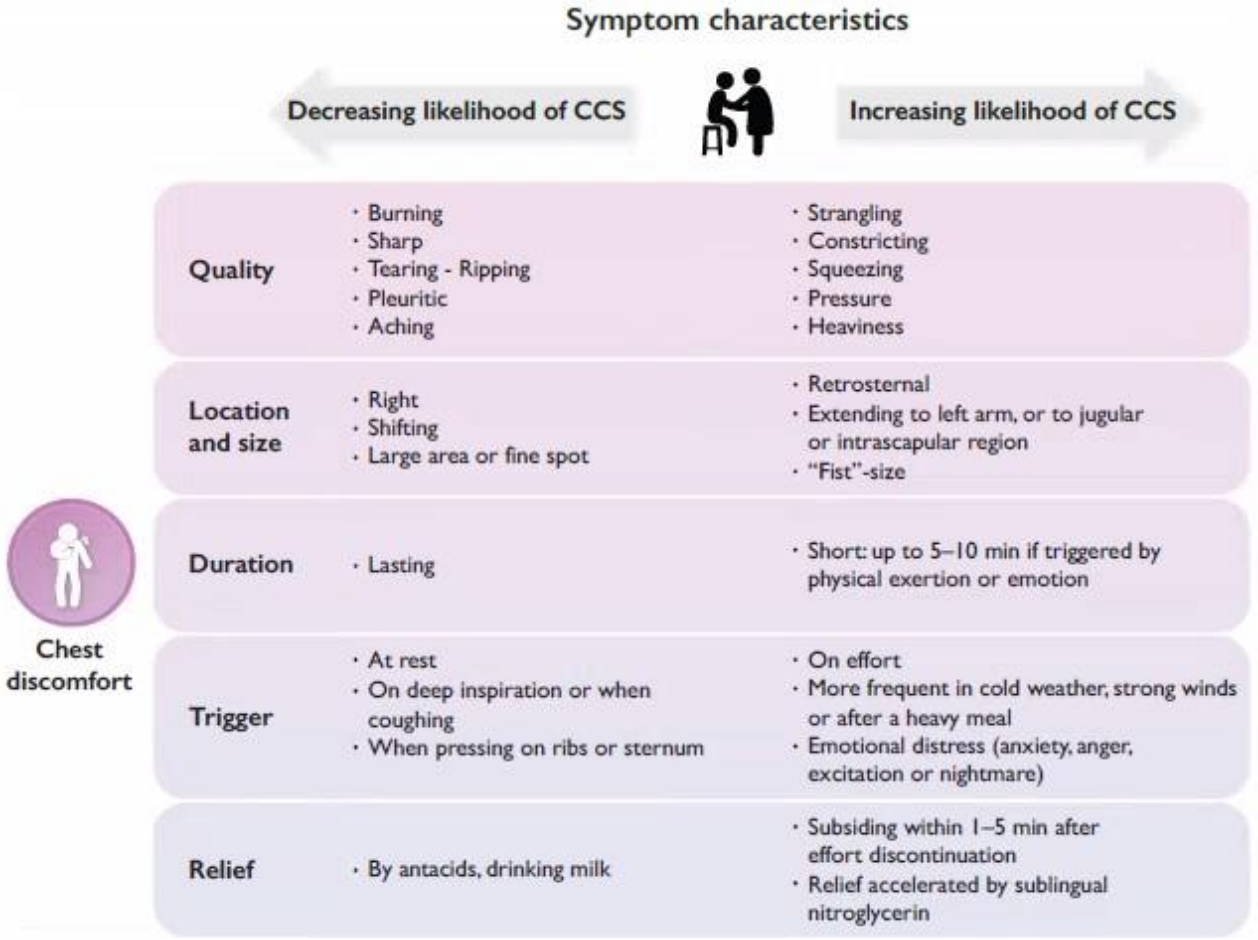
Chronisch Coronarialijden (CCS)

1. Symptomen
2. Onderzoek: afhankelijk van risico
3. Medicatie
4. Revascularisatie
5. ANOCA/INOCA

1. Symptomen



Symptom characteristics

	Decreasing likelihood of CCS	Increasing likelihood of CCS
Quality	· Burning · Sharp · Tearing - Ripping · Pleuritic · Aching	· Strangling · Constricting · Squeezing · Pressure · Heaviness
Location and size	· Right · Shifting · Large area or fine spot	· Retrosternal · Extending to left arm, or to jugular or intrascapular region · "Fist"-size
Duration	· Lasting	· Short: up to 5–10 min if triggered by physical exertion or emotion
Trigger	· At rest · On deep inspiration or when coughing · When pressing on ribs or sternum	· On effort · More frequent in cold weather, strong winds or after a heavy meal · Emotional distress (anxiety, anger, excitation or nightmare)
Relief	· By antacids, drinking milk	· Subsiding within 1–5 min after effort discontinuation · Relief accelerated by sublingual nitroglycerin

Chest discomfort

Typische angor:

10-25%

♂ = ♀

Atypische klacht:

50-70%

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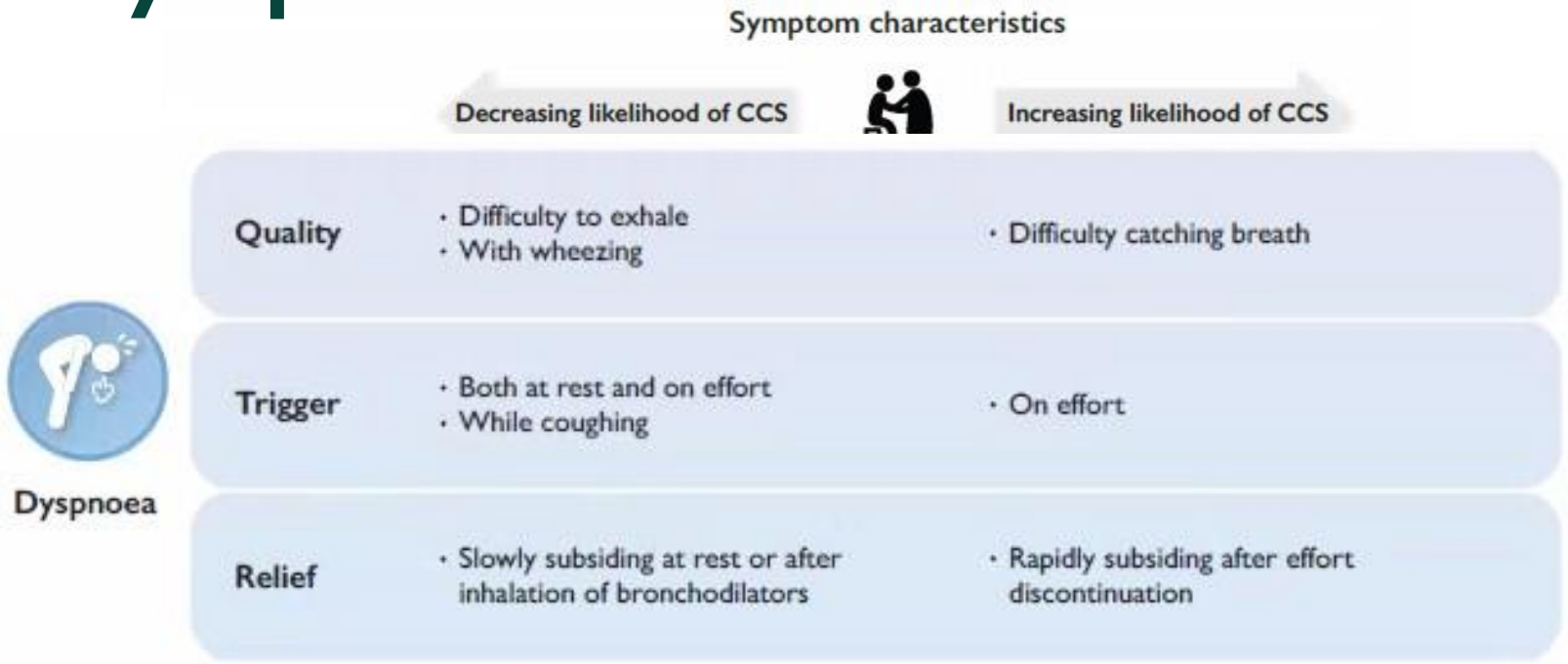
1. Symptomen



Dyspnoe:

10-15%

Asymptomatisch:

- Diabetes met autonome neuropathie
- Ouderen met erg sedentaire levensstijl

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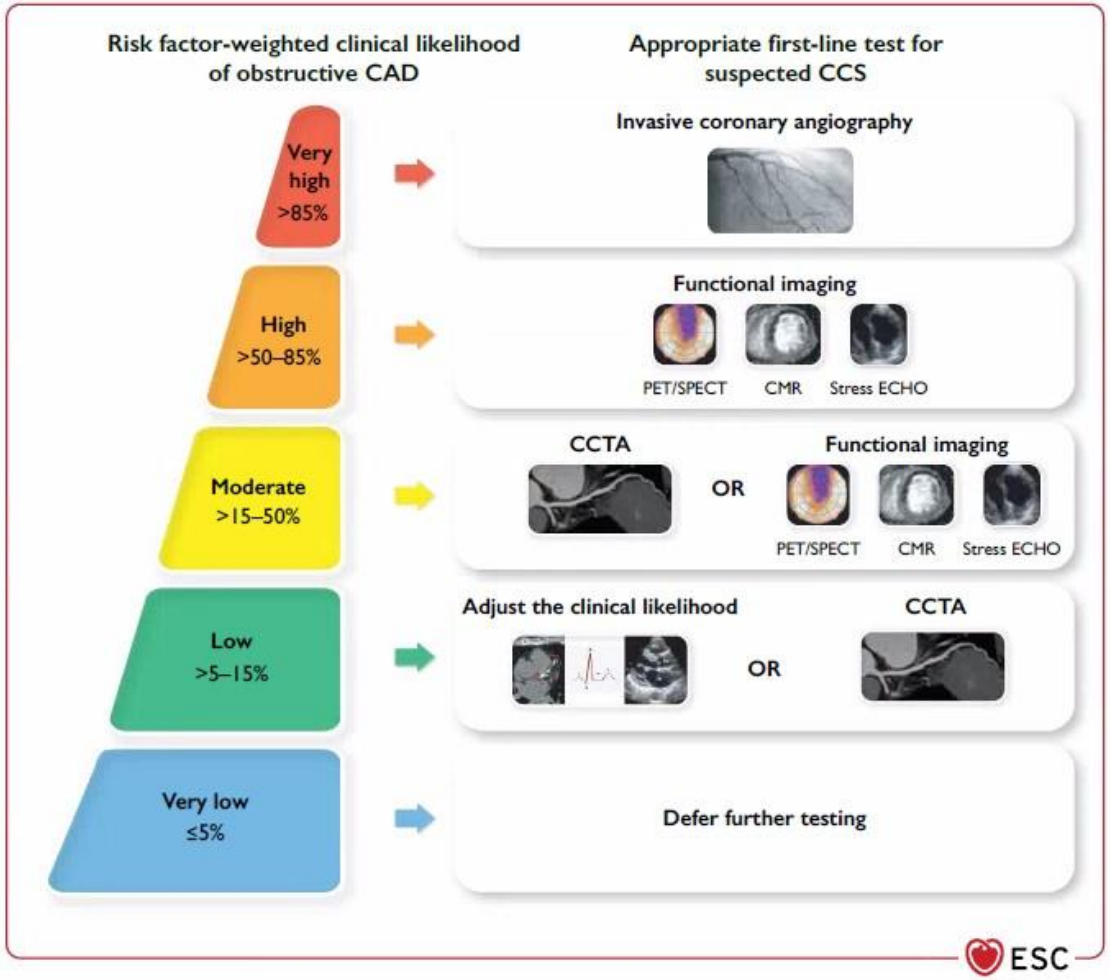
2. Onderzoek: afhankelijk van risico



België: CT cor enkel terugbetaald als aanvraag door cardioloog

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3. Medicatie

- Symptomen:
  - Cedocard SL zo nodig
  - 1e lijn: Bèta blokker of Calcium antagonist
  - 2e lijn: Bèta blokker en Calcium antagonist
  - 3e lijn: langwerkend nitraten
- Prognose:
  - Secundaire preventie: Aspirine (75-100 mg) of Clopidogrel
  - Ernstig coronarialijden (bv. op CT) zonder event: Aspirine
  - Zeer hoog ischemisch risico: Aspirine + Clopidogrel of Rivaroxaban (2 x 2,5 mg)
  - Na PCI: Aspirine + Clopidogrel 6 maanden
  - Na PCI met hoog bloedingsrisico: Aspirine + Clopidogrel 1-3 maanden
  - Na PCI met ook VKF: NOAC + Clopidogrel 6-12 maanden, dan enkel NOAC

3. Medicatie

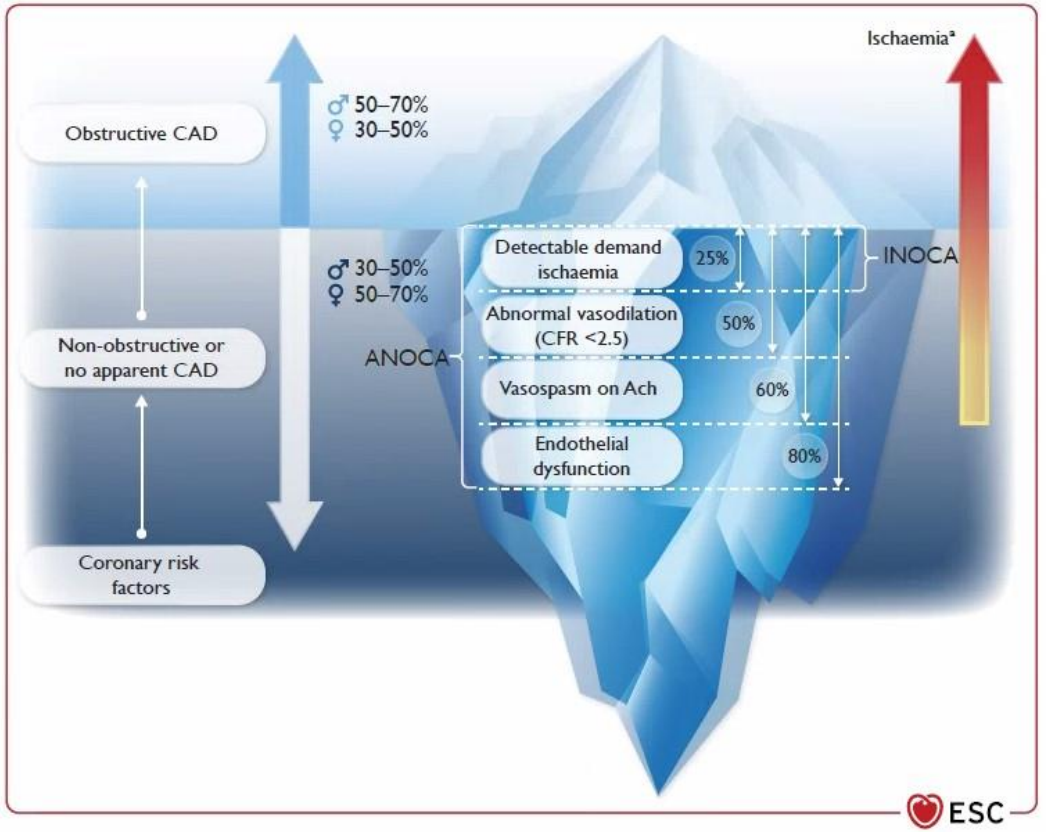
- Prognose:
  - Cholesterol: LDL < 55
    - 1e lijn: Statine
    - 2e lijn: + Ezetimibe
    - 3e lijn: + Bempedoïnezuur (terugbetaling: >55) of PCSK-9 (terugbetaling: >100)
    - (geen fibraten, plantensterolen, Becel…)
  - Diabetes: SGLT-2 inhibitor + GLP-1 agonist (niet terugbetaald in België)
  - BMI > 27: GLP-1 agonist (niet terugbetaald in België)
  - Colchicine 0,5 mg

4. Revascularisatie

- PCI of CABG voor symptomen
- PCI of CABG voor prognose (minder CV overlijden, minder AMI)
  - Bij hoofdstam stenose
  - Bij 3-taksziekte
  - Bij 1 of 2-taksziekte met proximale LAD stenose
- CABG voor prognose
  - Bij EF <35% (tenzij hoog operatief risico: overweeg PCI)
  - Bij DM en 3-taksziekte (tenzij hoog operatief risico: overweeg PCI)
- Steeds multidisciplinair overleg in Heartteam

5. ANOCA/INOCA

- Angor/Ischemie zonder Obstructief Coronarialijden



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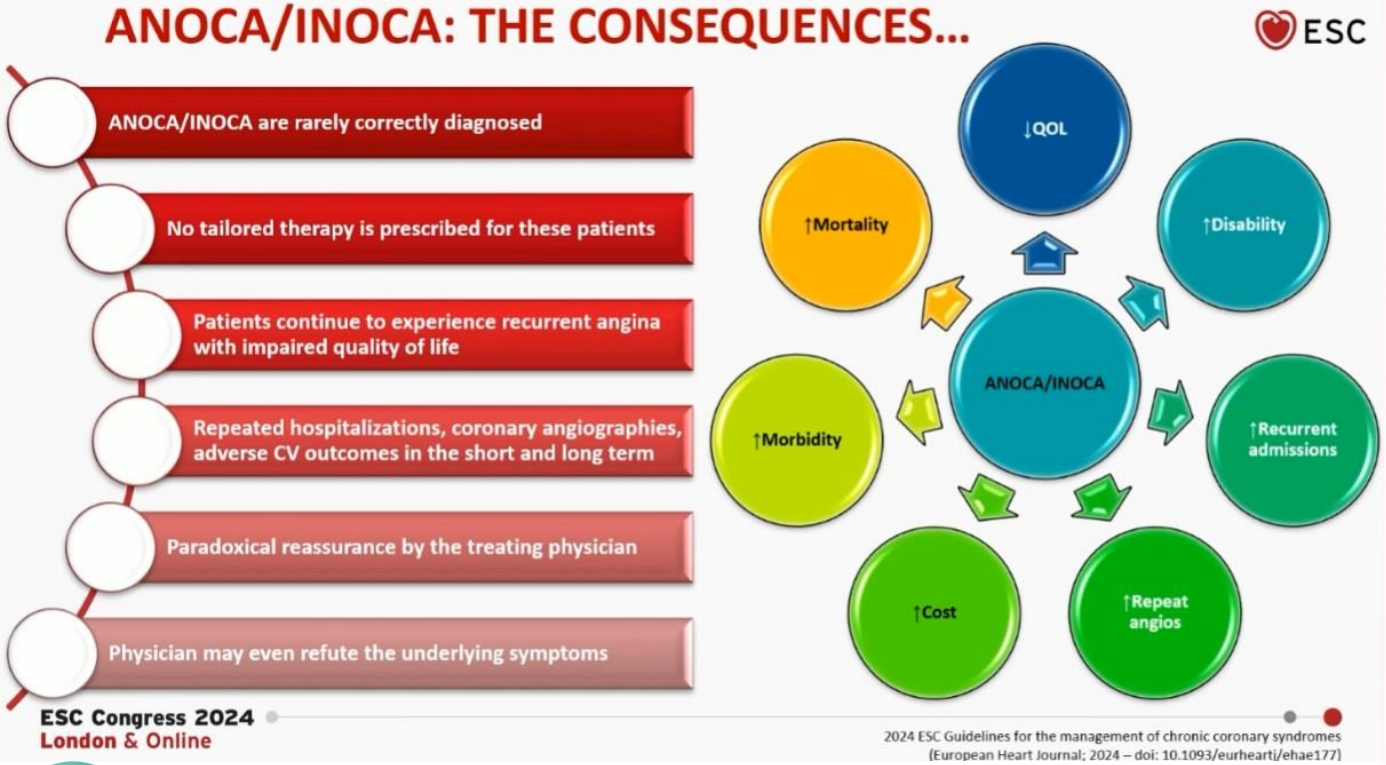

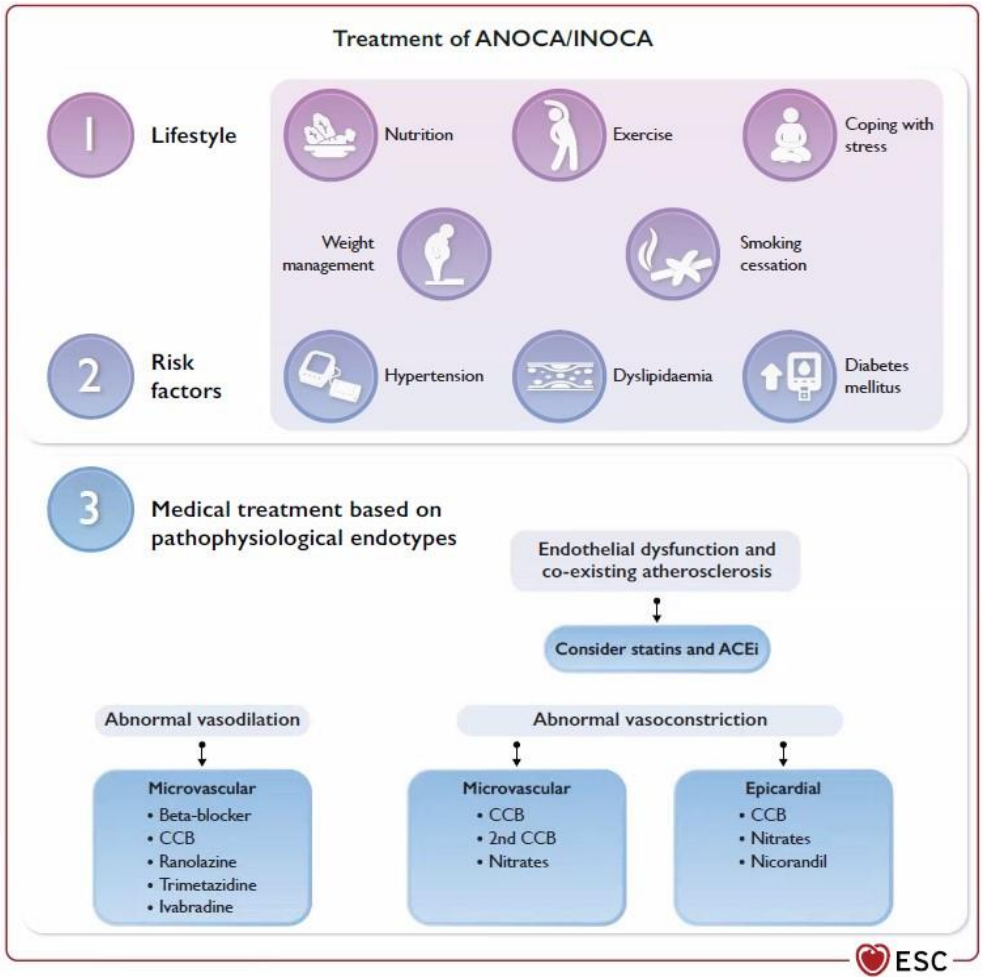

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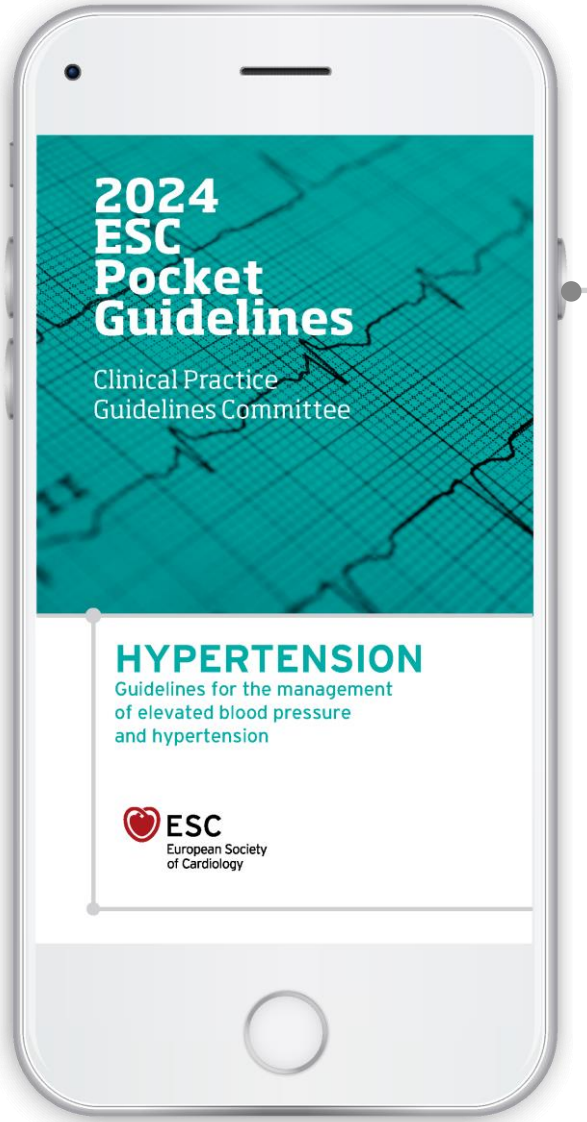

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- **Essential messages**

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Bevestig je deelname met de **QR-code**

Practopics

Praktische topics voor de huisarts

Of **klik op de link** in de Q&A rechtsboven.

Volg ons op **zas.be** en

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