A Bridge Over Troubled Water – Major Surgery Early After Coronary Stenting in a Patient with Elevated Bleeding Risk

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INTRODUCTION

- A 70-year-old male patient was admitted due to generalized weakness and jaundice.
- An MSCT scan (**Figure 1A**) revealed a mass in the head of the pancreas with no visible dissemination or vascular invasion.
- Two months earlier the patient underwent elective percutaneous coronary intervention (PCI) of the LAD, whereas, eight days earlier PCI of the LCx/OM1 **(Figure 1B)**. Acetylsalicylic acid and ticagrelor were introduced as chronic therapy.

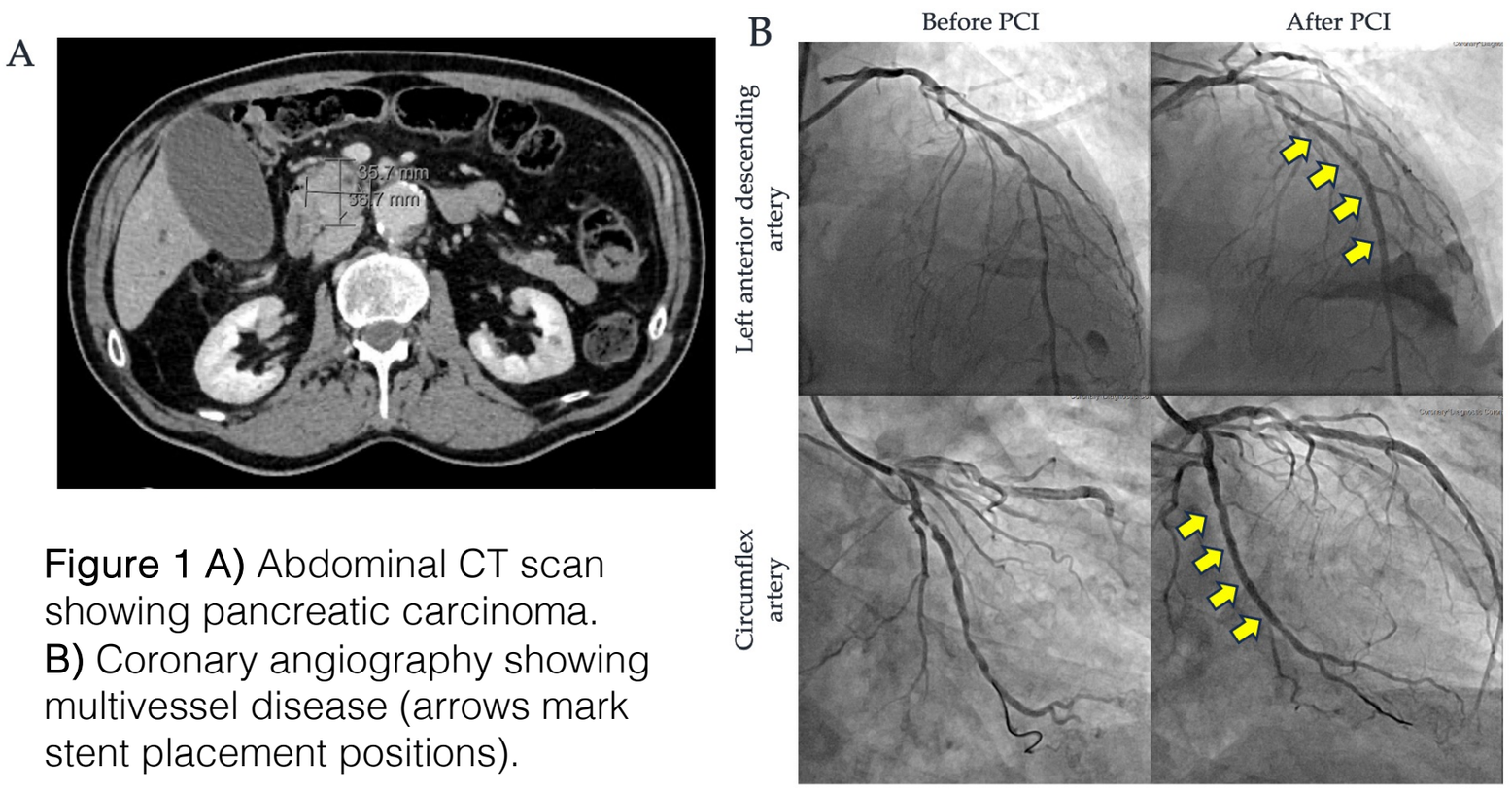

Figure 1 A) Abdominal CT scan showing pancreatic carcinoma. **B)** Coronary angiography showing multivessel disease (arrows mark stent placement positions).

CLINICAL COURSE (Timeline is shown in **Figure 2**)

- The case was discussed at the multidisciplinary meeting and urgent pancreaticoduodenectomy was recommended.
- The patient was ruled as a high-bleeding risk due to active malignancy and NCS required on DAPT, and high-thrombotic risk due to PCI interventions performed within the past 2 months on multiple vessels, with 4 implanted stents related to a large myocardial territory. The consortium weighted the thrombotic risk as clinically relevant, and bridging with IV eptifibatide was recommended (
- Ticagrelor was discontinued five days before the NCS. On the same night the patient experienced rectal bleeding - polypectomy was performed in the 48-hour window after P2Y12 discontinuation and before eptifibatide initiation, removing three polyps.
- Eptifibatide was initiated 4h after polypectomy. Surgery was performed without problems achieving hemostasis and periprocedural thrombotic events, revealing no local metastatic disease. A loading dose of clopidogrel was given six hours following the end of the procedure. A switch of P2Y12 inhibitors back to ticagrelor was performed, and the patient discharged eight days after admission.
- An adjuvant chemotherapy protocol with gemcitabine was administered through 4 months, with no relapse at 8 months follow-up.

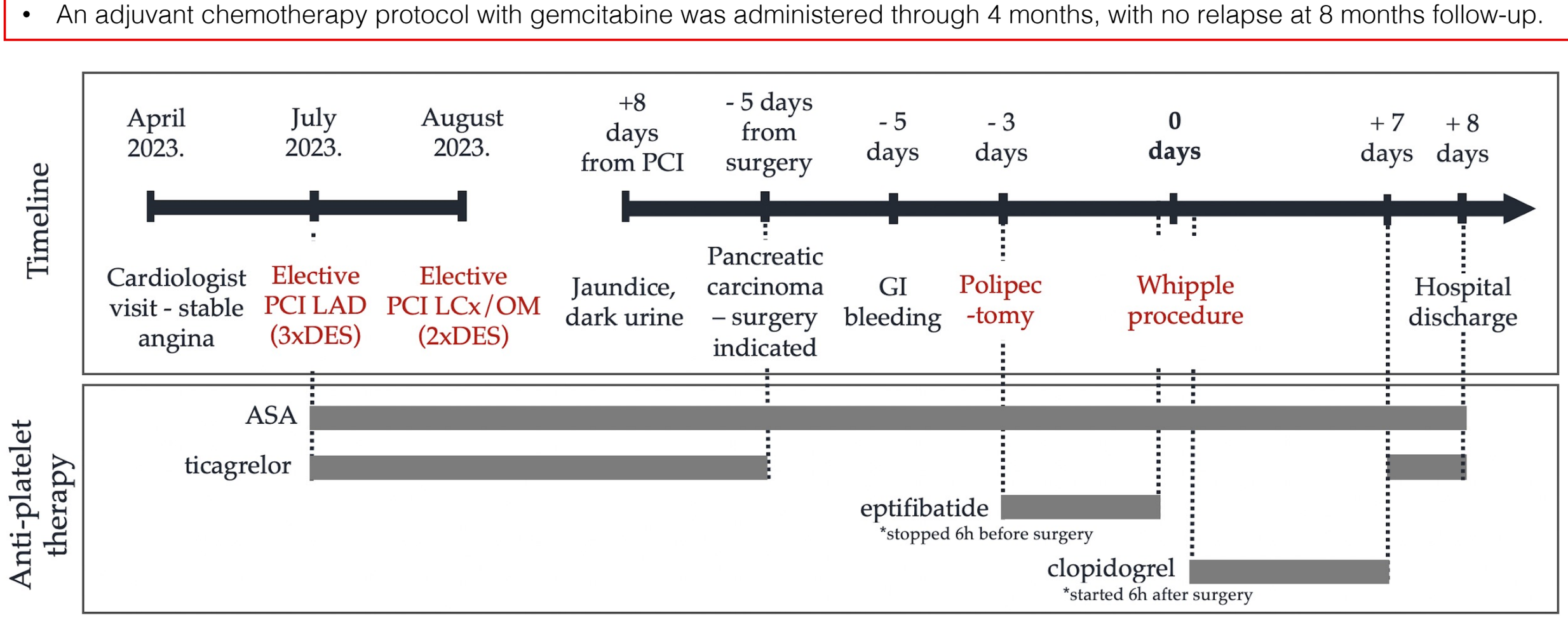

Figure 2 – A timeline of clinical events and periprocedural antiplatelet therapy (ASA - acetylsalicylic acid, GI – gastrointestinal)

CONCLUSION

- The decision to perform NCS early after PCI should be guided by a multidisciplinary team and patient preference to achieve the most favorable outcome.
- Decision on cessation of antiplatelet therapy in bleeding events should be based on clinical recommendations and tailored to the overall thrombosis and bleeding risk.
- Perioperative bridging with intravenous antiplatelet agents may be considered in specific clinical scenarios.

REFERENCES: Halvorsen S, Mehilli J, Cassese S, Hall TS, Abdelhamid M, Barbato E, et al. 2022 ESC Guidelines on cardiovascular assessment and management of patients undergoing non-cardiac surgery: Developed by the task force for cardiovascular assessment and management of patients undergoing non-cardiac surgery of the European Society of Cardiology (ESC) Endorsed by the European Society of Anaesthesiology and Intensive Care (ESAIC). Eur Heart J. 2022;43:3826–924.