Title: ESC 23: New Guidelines For the Management of Acute Coronary Syndromes
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2023 ESC Guidelines for the Management of Patients with Acute Coronary Syndrome

Professor Byrne: My name is Professor Robert Byrne. I'm a cardiologist. I work as Director of Cardiology at Mater Private Network in Dublin, Ireland, and I'm Professor of Cardiovascular Research at the Royal College of Surgeons in Ireland University in Dublin, Ireland. My presentation today was on the 2023 ESC Guidelines for the Management of Patients with Acute Coronary Syndrome.

1. What are the unmet needs of ACS patients in 2023?

Professor Byrne: I think the first thing to realize about acute coronary syndromes is it's a very broad spectrum of conditions, and the clinical presentation can vary from a very stable patient to a patient who's critically ill. In the past, there were separate guidelines for advising on the management of patients with ST-elevation myocardial infarction and there were separate guidelines for advising on the management of patients with non-ST-elevation acute coronary syndrome. And it was felt that now it was time for the two to come together.
There's lots of information out there, there's lots of studies, but try to synthesize everything in a single guideline on acute coronary syndrome. And I think this was an unmet need and hopefully we've delivered on this in our document, which is a large document. It considered, for example, information from 936 different manuscripts to give a large number of recommendations, which we hope will be helpful for the community.

2. What is new in the guidelines?

Professor Byrne: I think the first thing is that the guidelines is a combined guideline. As I've just mentioned, we try to outline a common pathway for the treatment of all patients with acute coronary syndrome, asking people to remember a couple of things. Think straight away about an invasive management strategy, think straight away about what antithrombotic treatment strategy that you're going to use, think straight away about revascularization and then finally think straight away already how you're going to prevent the next acute coronary syndrome by focusing on secondary prevention.
One of the changes, I suppose, when we think upfront about the invasive strategy is in patients with ST-elevation myocardial infarction, there isn't a major change. At first point of contact, you have to ask yourself, can this patient be treated with primary angioplasty inside 120 minutes? And if yes, you do that, if the patient can't be treated within 120 minutes, in the opinion of you and your team, then you need to go with fibrinolysis first and then an invasive strategy after that.
That hasn't changed much in terms of non-ST-elevation acute coronary syndrome. Also, the basics of management remain the same. An invasive strategy should be preferred. There are certain high-risk features, so we know if you've got an established diagnosis of myocardial infarction, then your

invasive strategy should be fast-tracked. Previously there was a Class I recommendation, in fact, to do this within 24 hours.
Now some more data has become available, and an updated meta-analysis and we felt really a Class IIa recommendation would be preferable in this situation. So, there's a slight downgrade in the recommendation for invasive management in non-ST-elevation acute coronary syndrome in relation to anticoagulant and antithrombotic therapy.
The recommendations of the 2017 Guidelines on STEMI and the 2020 Guidelines on Non-ST-elevation Acute Coronary Syndrome have been largely maintained. But this wasn't an easy decision because there were lots of new studies that came out in the meantime. For example, in relation to antiplatelet therapy, the default position remains aspirin combined with a potent P2Y12 inhibitor, which should be continued for twelve months. Now, we realize that there are many studies out there which also examined a shorter duration of dual antiplatelet therapy combined thereafter with P2Y12 inhibitor monotherapy or aspirin monotherapy. And so, they're represented in the guideline as an alternative strategy and I think this is clearly presented in the guideline.

3. Is there any area that needs more attention?

Professor Byrne: Well, we've seen already that in terms of the trials that are scheduled for presentation at the ESC meeting where the guidelines are being presented, already, there will be many trials being published which might impact on the guidelines. And I think an important thing to note is that the European Society of Cardiology now has provision to do regular focused updates of the guidelines. So, if there are new information emerging at this meeting which is relevant for the guidelines, they can be considered rapidly with, if needed, a focused update in two years, rather than having to wait four to five years for a further update.
So there's going to be information coming out on the management of patients with cardiogenic shock, there'll be more information on antiplatelet therapy, there'll be more important studies on intravascular imaging which will be presented straight away at this meeting.

4. What are some of the challenges and opportunities with the implementation of these recommendations?

Professor Byrne: I think the dissemination of the guidelines' information is always something that we can look to do better. We want to reach as many people involved in the care of these patients as possible. We also plan a guideline for patients and that's being worked on at the moment. W e've come up with a central animation or video of the guidelines which you'll find on the ESC website in order to try and reach as many stakeholders as possible in a 90-second summary. And I think getting the information out there is the first part.
Now there are a suite of quality indicators which are also in preparation and will be published soon, and that will help those that are in positions of responsibility to look at a national level or an institutional level in how the guidelines are implemented.
I think that will provide a useful metric in order to measure how good centers and how good countries are at implementing the guidelines. Because if you can't measure it, then of course you can't change it, and hopefully this will be an important contribution for the community.