Vascular Protection in Patients with Peripheral Artery Disease: Improving Outcomes with Dual Pathway Inhibition – The COMPASS Study

12:30–13:25, Tuesday 30 January 2018
Room 2, Main Arena 2

This meeting has been fully organised and funded by Bayer AG, Berlin, Germany
Welcome and Introduction

Professor Dr Dierk Scheinert
Chairman, Department of Angiology
University Hospital Leipzig, Germany
202 Million People Worldwide Are Estimated to Be Living with Lower Extremity PAD

Estimated age-specific prevalence of men and women living with lower extremity PAD in 2010

Prevalence (%) vs Age

- Women (high income countries)
- Women (low and middle income countries)
- Men (high income countries)
- Men (low and middle income countries)

Fowkes FGR et al, Lancet 2013;382:1329–1340
Treatment Options for the Prevention of Cardiovascular Events Are Limited in Patients with PAD

2017 ESC/ESVS guidelines for the management of PAD

Management of antiplatelet therapy in patients with lower extremity arterial disease not requiring anticoagulation

Asymptomatic

- No SAPT*
  - Class III A

Symptomatic

- SAPT#
  - Class I A
  - A or C

Revascularization

Percutaneous

- DAPT A + C
  - Class Ila C

Surgery

- SAPT‡
  - A or C
  - Class Ila C

- VKA‡
  - Class Iib B
  - O

- Aspirin 75–100 mg/day
- Clopidogrel 75 mg/day
- Oral anticoagulation

Time delay

- 0
- 1 month
- 1 year
- Long term

*SAPT should be considered if CAD/CAS; †DAPT may be considered if ACS/PCI <1 year or complex PCI; ‡evidence is weak and risk of bleeding doubles compared with SAPT

COMPASS Investigated a Dual Pathway Approach in Patients with Chronic PAD and/or CAD

**Objective:** To determine the efficacy and safety of rivaroxaban 2.5 mg bid plus aspirin, rivaroxaban 5 mg bid alone or aspirin alone for reducing the risk of CV death, MI and stroke in patients with CAD or PAD

**Population:**
- Chronic CAD (91%)
- PAD (27%)

**Antithrombotic investigations** were stopped 1 year ahead of expectations in February 2017 because of overwhelming efficacy in the rivaroxaban vascular dose 2.5 mg bid plus aspirin arm.

*Patients who were not receiving a PPI were randomized to pantoprazole or placebo (partial factorial design); the PPI pantoprazole component of the study is continuing; data will be communicated once complete*

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<td>Dierk Scheinert, Germany (Chair)</td>
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<td>Vascular protection in patients with CAD and PAD: new options</td>
<td>Sebastian Debus, Germany</td>
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<td>From registries to clinical trials: impact on guidelines for PAD</td>
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<td>PAD: from post-intervention to the chronic state</td>
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