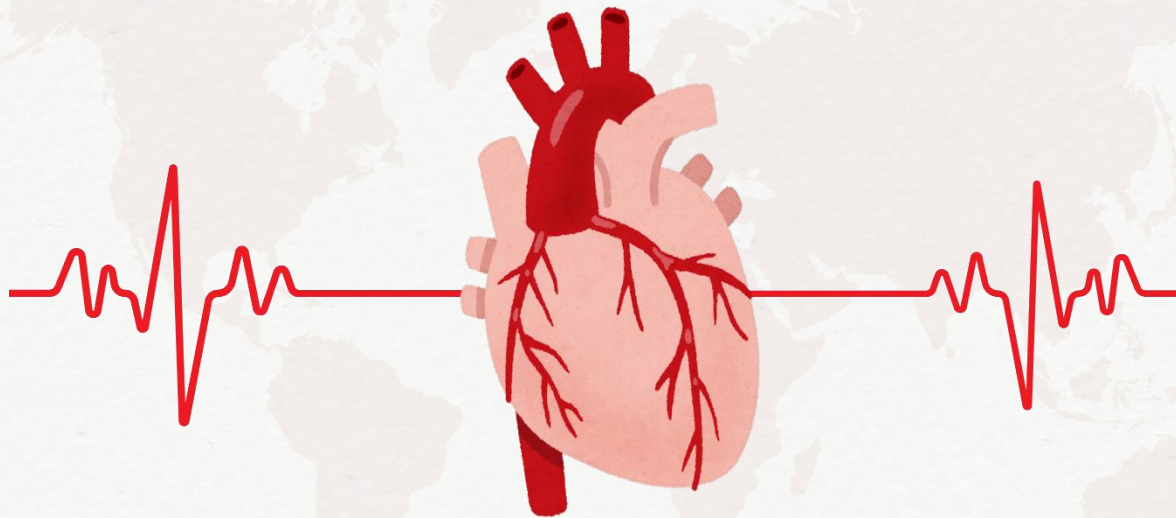


Prikaz slučaja

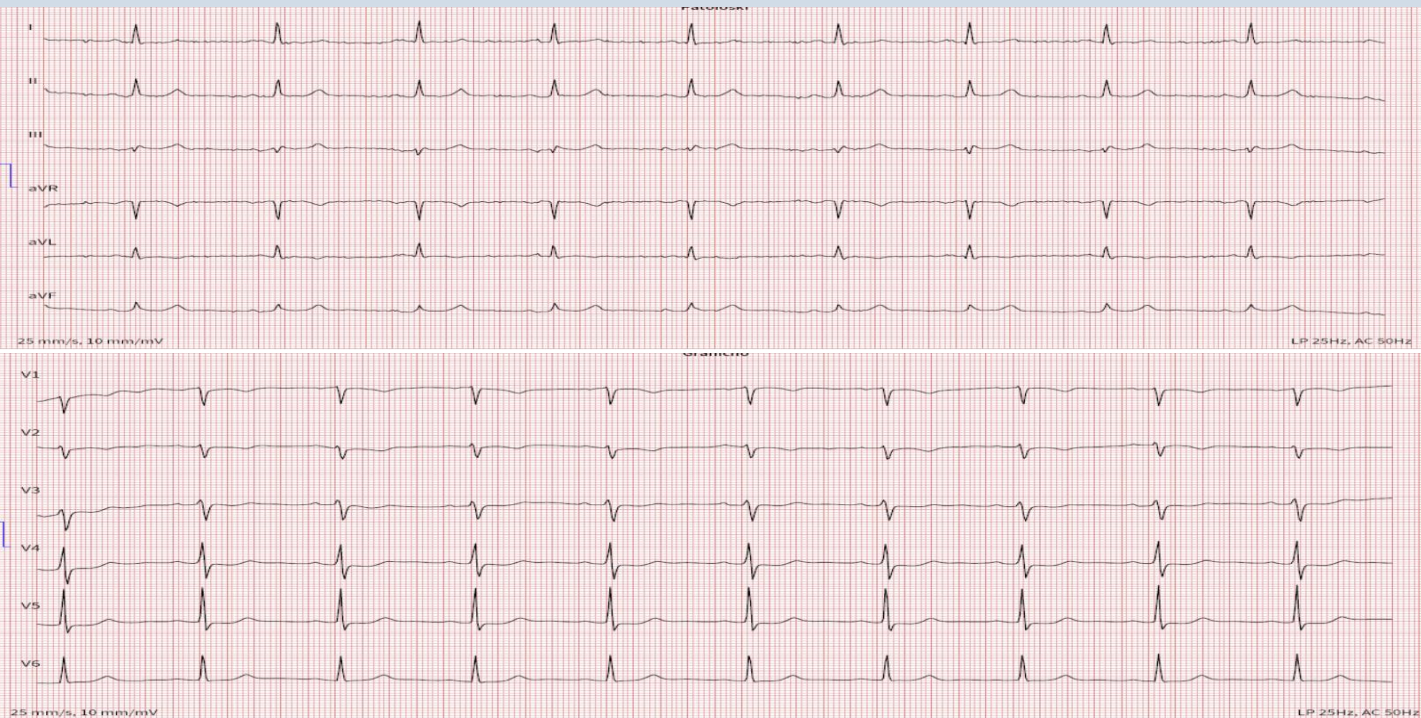


*Dr med. Miloš Majstorović,
spec. kardiolog, UKC RS*

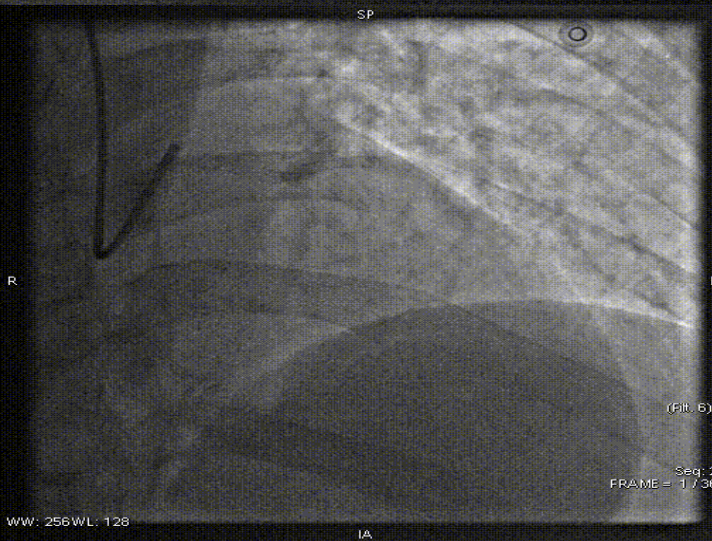
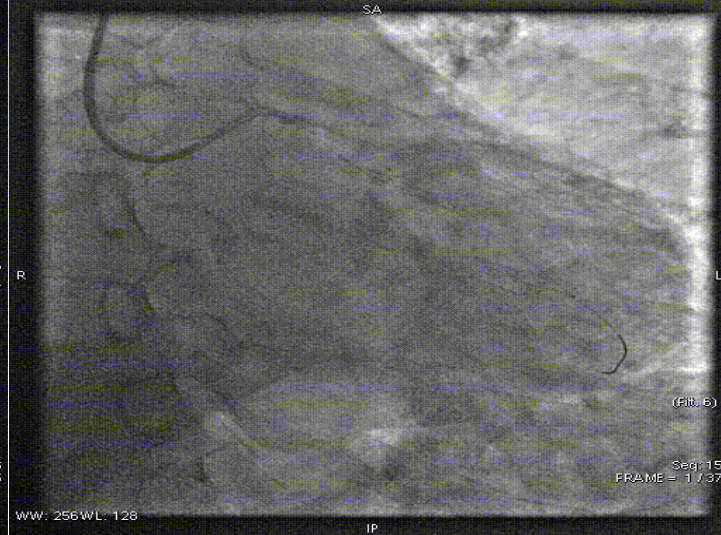
Banja Luka, 26.09.2026.

- ▶ Pacijent muškog pola, starosti 55 godina, TV 182 cm, TT 99 kg BMI 30 kg/m²
- ▶ Anamnestički: Subjektivno prisutne tegobe u vidu iznenadno nastalog bola u grudima (7/10) bez propagacije i izraženog nedostatka vazduha, koje su se javile oko 6 sati pred trenutni pregled, trajale oko 3 časa, potom djelimično spontano popustile. Navodi da i u trenutku pregleda i dalje ima bol u grudima, nešto manjeg intenziteta (3/10). Ostale tegobe po sistemima negira. Od ranije je hipertoničar pod terapijom (Perindopril/indapamid 4/1,25mg 1x1, Aspirin tbl a 100mg 1x1, Rosuvastatin tbl a 20mg 1x1).
- ▶ Prije četiri godine radjena koronarografija, PCI RCA i Cx, opisano neznajno suženje proksimalne LAD.
- ▶ Negira konzumiranje alkohola, pušač unazad 10 godina- 20ak cigareta dnevno. Negira dijabetes mellitus. Negativna porodična anamneza za KVB. Negira alergiju na hranu i lijekove.

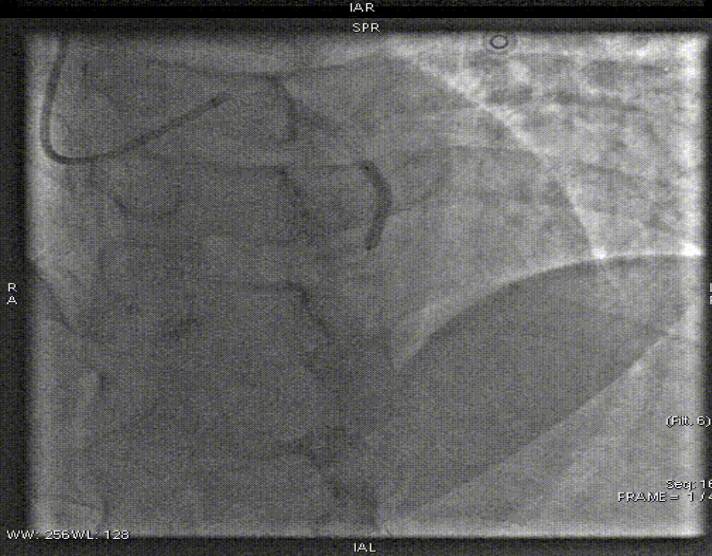
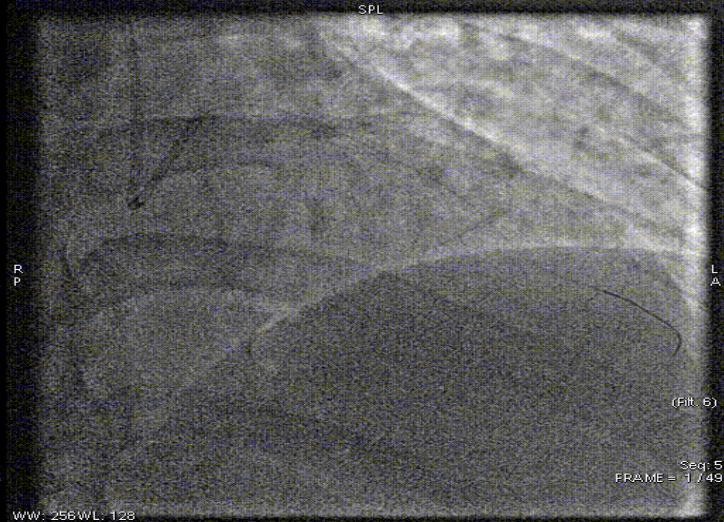
- ▶ Status: svjestan, orjentisan, koža i vidljive sluznice normalne prebojenosti. Cor: srčana akcija ritmična, tonovi jasni, šum ne čujem, TA 145/91mmHg (desna ruka), 145/95 (lijeva ruka). Pulmo: normalan disajni šum. Abdomen: u ravni grudnog koša, mek, bezbolan. Ekstremiteti: bez edema, palpabilnih pulseva
- ▶ Laboratorijski nalazi: RBC : 4.25 , WBC : 10.07 , HGB : 115 , HCT : 0.37 MCV : 87.5 , MCH : 27.1 , Mchc : 309 ,Plt : 292 D-dimer: 0.33 , Glukoza: 9.2 , Urea: 4.3 ,Kreatinin: 69, **hs Troponin T stat: 2250, Ck: 176 CK-MB: 33 , Crp: 10.18 , NT-proBNP: 2651.0** HBA1(c) : 5.7% HBA(1c) : 38.8 Holesterol ukupni: 4.6 Holesterol HDL: 1.4 Holesterol **LDL: 2.7** Trigliceridi: 1.0 TSH: 0.61 FT4: 17.15
- ▶ Fokus ehokardiogram je pokazao blagu disfunkciju lijeve komore (ejekcijska frakcija lijeve komore EF 50%) s hipokinezom anterolateralnog zida LK.
- ▶ RTG pluća i srca, PA, stojeći: U plućnom parenhimu nema rtg znakova infiltracije niti konsolidacije. Hilusi primjerene širine. Kupole dijafragme na normalnom mjestu položene, pravilno svedene, lat.FC sinusi slobodni. Srce primjerene veličine

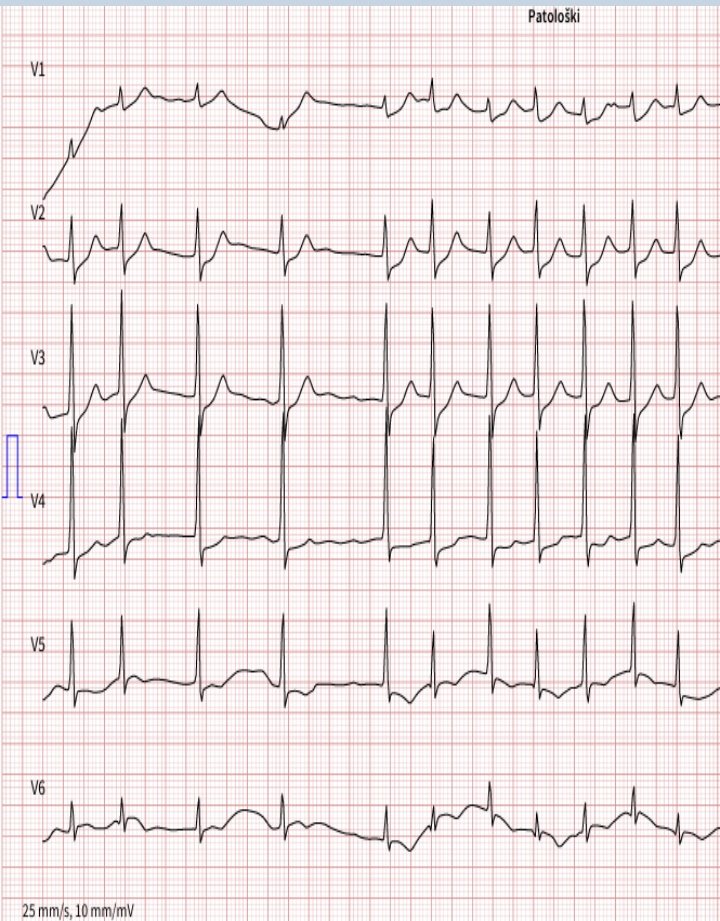
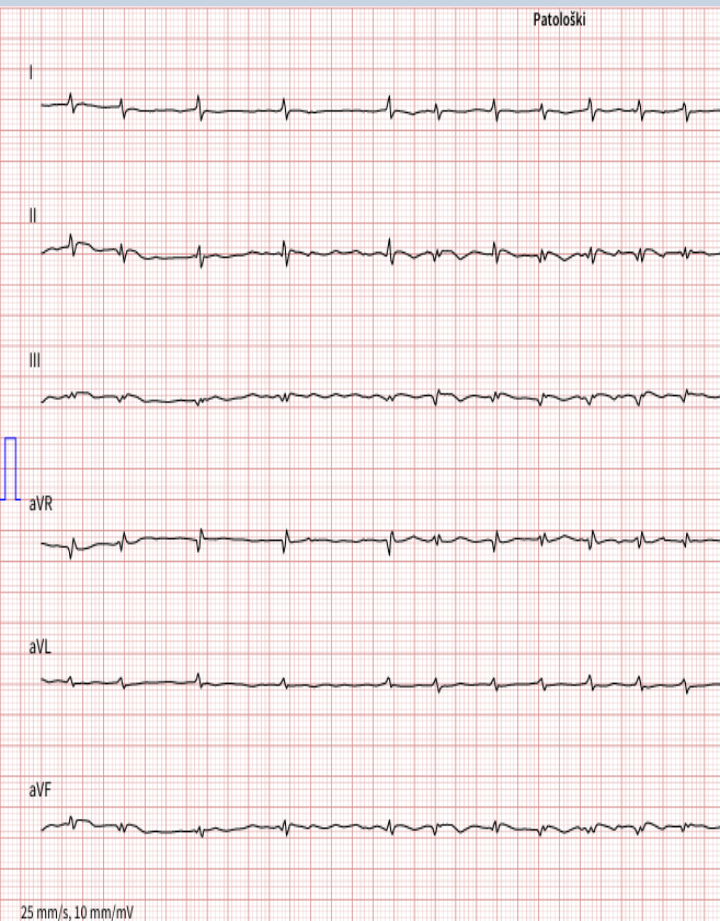


EKG: sinus ritam, fr. 60/min, normogram, ST depresija do max 1 mm V3-V5 sa bifaznim T talasom aVL, V2-V3, rs D3.



► Uradi se iFR LAD
kojim se dobije
vrijednost 0.84





EHOKARDIOGRAFIJA

Left ventricular mass index and relative wall thickness

Major criterion: LVMI ≥ 149 g/m² in men or ≥ 122 g/m² in women and RWT > 0.42

Minor criterion: LVMI ≥ 115 g/m² in men or ≥ 95 g/m² in women or RWT > 0.42 or LV end-diastolic wall thickness ≥ 12 mm

$$LVM = 0.8 \times 1.04 \times [(IVS_d + LVID_d + PWT_d)^3 - LVID_d^3] + 0.6$$

13/13 mm
150g/m2
0,83 RWT

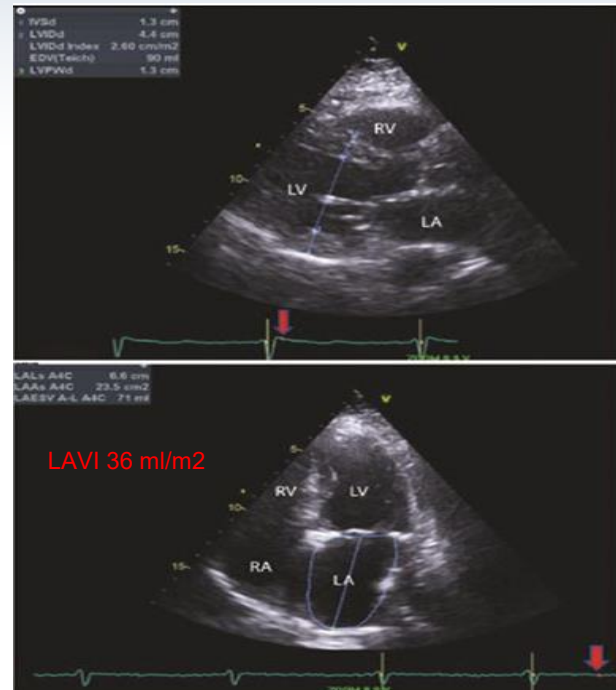
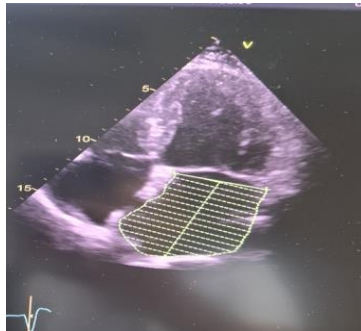
Left atrial volume index

Major criterion: > 34 mL/m² [in sinus rhythm]

Major criterion: > 40 mL/m² [in atrial fibrillation]

Minor criterion: $29 - 34$ mL/m² [in sinus rhythm]

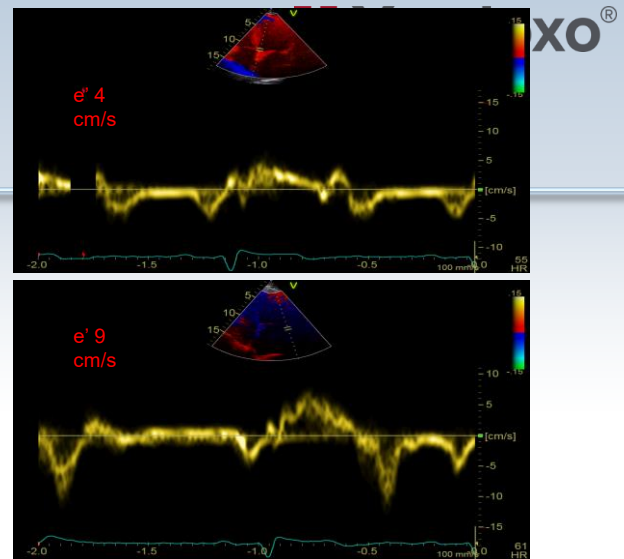
Minor criterion: $34 - 40$ mL/m² [in atrial fibrillation]



Septal and lateral mitral annular peak early diastolic velocity (e')

Major criterion : septal $e' < 7$ cm/s, or lateral $e' < 10$ cm/s [subjects aged < 75 years]

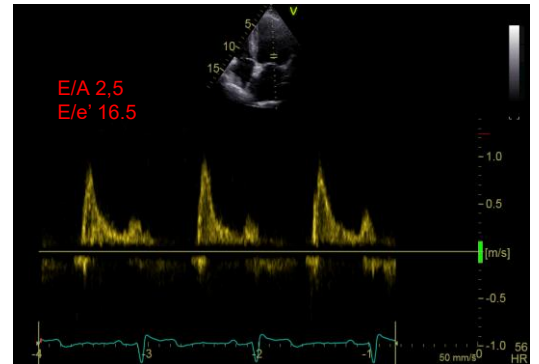
Major criterion : septal $e' < 5$ cm/s, or lateral $e' < 7$ cm/s [subjects aged ≥ 75 years]



Average septal-lateral E/e' ratio

Major criterion : average septal-lateral E/e' ratio ≥ 15

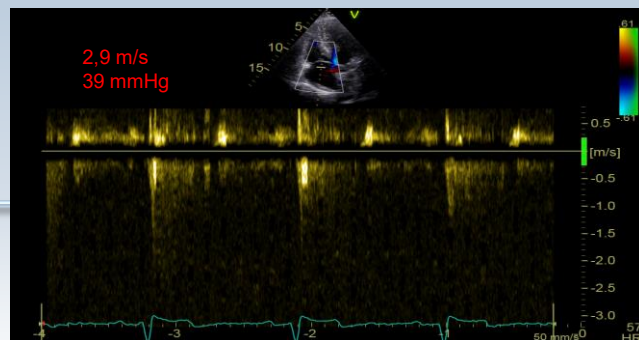
Minor criterion : average septal-lateral E/e' ratio 9 – 14



Tricuspid regurgitation peak velocity or pulmonary arterial systolic pressure

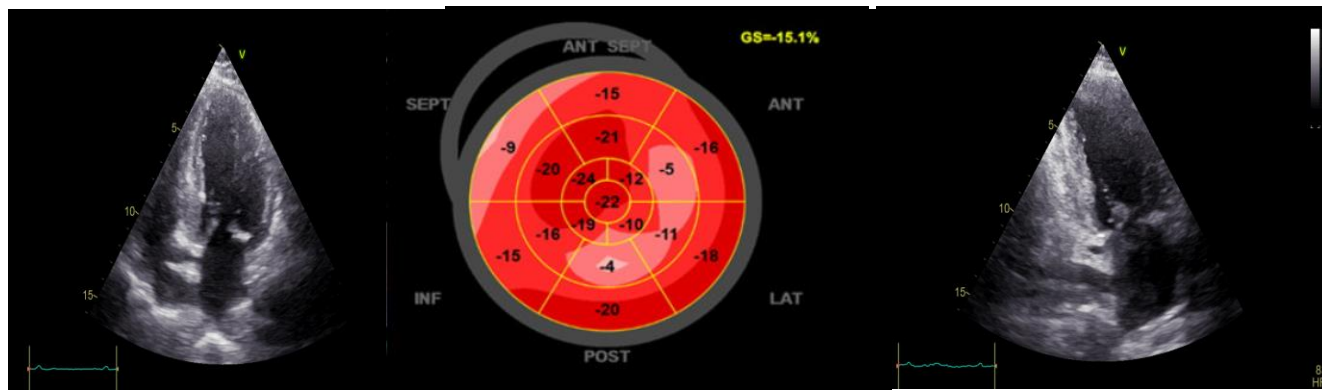
Major criterion : TR peak velocity > 2.8 m/s

Major criterion : Pulmonary artery systolic pressure > 35 mmHg



Left ventricular global longitudinal systolic strain

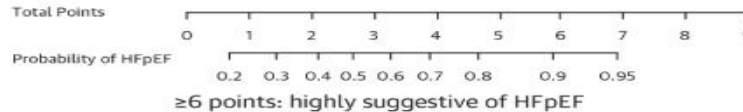
Minor criterion : GLS < 16%



Dijagnostički algoritam HFA-PEFF

H₂FPEF Score

H2	Heavy (BMI >30 kg/m ²) On ≥2 antiHypertensives	2 1
F	Atrial Fibrillation	3
P	Pulmonary hypertension (PASP >35 mm Hg on Doppler echocardiography)	1
E	Elder (age >60 years)	1
F	Filling pressure (E/e' >9 on Doppler echocardiography)	1



HFA-PEFF Score

P	Pretest assessment
- Symptoms and/or signs of heart failure - Comorbidities/risk factors - Standard echocardiography	
E	Echo and natriuretic peptide score
- Comprehensive echocardiography - Natriuretic peptides	
F1	Functional testing in case of uncertainty
- Diastolic stress test (exercise echocardiography) - Invasive hemodynamic measurements	
F2	Final etiology
- Special imaging (CMR, CT, PET, scintigraphy) - Biopsies - Genetic testing	

Functional

Septal e' <7 cm/s OR
Lateral e' <10 cm/s OR
Average E/e' ≥15 OR
TR velocity >2.8 m/s
Average E/e' 9-14 OR
GLS <16%

Morphological

LAVI >34 mL/m² OR
LVMI ≥149/122 g/m² (M/F) AND
RWT >0.42
LAVI 29-34 OR
LVMI >115/95 g/m² (M/F) OR
RWT >0.42 CR
LV wall thickness ≥12 mm

Biomarker (Sinus rhythm)

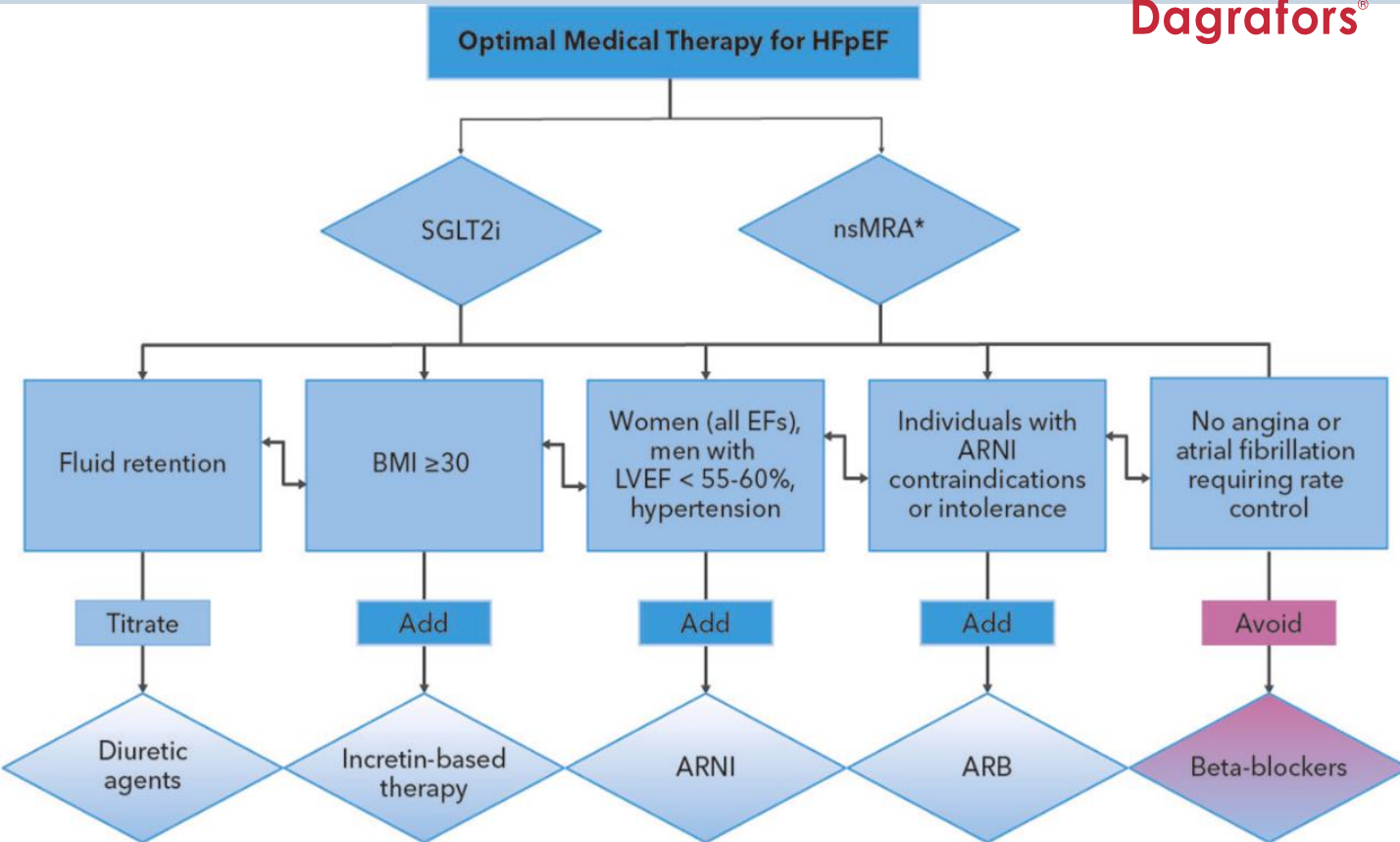
NT-proBNP >220 pg/mL OR
BNP >80 pg/mL
NT-proBNP 125-220 pg/mL OR
BNP 35-80 pg/mL

Biomarker (Atrial fibrillation)

NT-proBNP >660 pg/mL OR
BNP >240 pg/mL
NT-proBNP 365-660 pg/mL OR
BNP 105-240 pg/mL

≥5 points: HFpEF

Major criteria (2 pts) bolded
Minor criteria (1 pt) non-bolded



Terapija na otpustu:

- Clopidogrel tbl 75 mg 1x1
- **Xerdexo tbl 20 mg 1x1**
- Sobycor tbl 2.5 mg 1x1
- Amlewel tbl 4/1.25/5 mg 1x1
- Roswera tbl 40 mg 1x1
- **Dagrafors tbl 10 mg 1x1**
- Nolpaza tbl 20 mg 1x1

HASBLED Score: 1

CHADS2VA Score: 3

Kreatinin klirens (Cockcroft-Gault fo): 132 ml/min

Table 1 Academic Research Consortium (ARC) Major and Minor Criterion For High Bleeding Risk

Major	Minor
	Age $\geq$ 75 years
Anticipated use of long-term oral anticoagulation*	
Severe or end-stage CKD (eGFR <30 mL/min)	Moderate CKD (eGFR 30-59 mL/min)
Hemoglobin <11 g/dL	Hemoglobin 11-12.9 g/dL for men and 11-11.9 g/dL for women
Spontaneous bleeding requiring hospitalization or transfusion in the past 6 months, or any time, if recurrent	Spontaneous bleeding requiring hospitalization or transfusion within the past 12 months not meeting the major criterion
Moderate or severe baseline thrombocytopenia (platelet count $<100 \times 10^9/L$)	
Chronic bleeding diathesis	
Liver cirrhosis with portal hypertension	
	Long term use of oral NSAIDs or steroids
Active malignancy (excluding nonmelanoma skin cancer) within the past 12 months	
Previous spontaneous intracranial hemorrhage	
Previous traumatic intracranial hemorrhage within the past 12 months	
Presence of brain AVM	
Moderate or severe ischemic stroke (NIHSS score ≥ 5) within the past 6 months	Any ischemic stroke at any time not meeting the major criterion
Nondeferrable major surgery on DAPT	
Recent major surgery or major trauma within 30 days before PCI	

Definition of high thrombotic risk

According to ACC/AHA DAPT guidelines

ACS, previous stent thrombosis while on antiplatelet treatment, and complex PCI (3 vessels treated, ≥ 3 stents implanted, ≥ 3 lesions treated, bifurcation with 2 stents implanted, total stent length >60 mm, surgical bypass graft or chronic total occlusion as target lesions, atherectomy device use, or left main PCI)

Definition of high ischemic risk

According to ACC/AHA DAPT guidelines

Previous myocardial infarction, multivessel CAD, polyvascular disease, diabetes mellitus, chronic kidney disease, heart failure

Patients with ACS and an indication for OAC

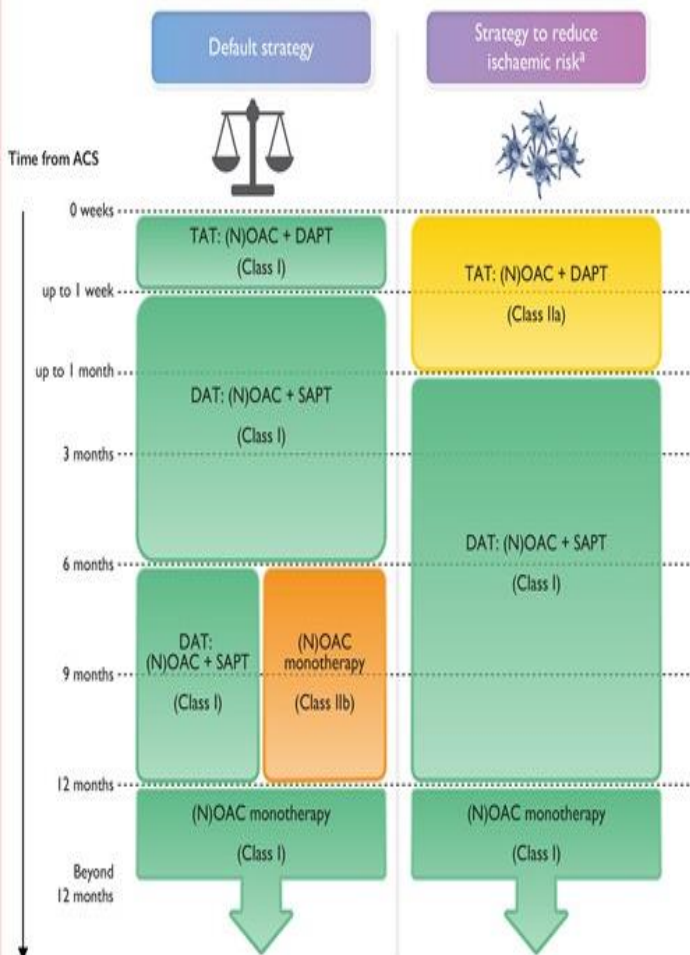
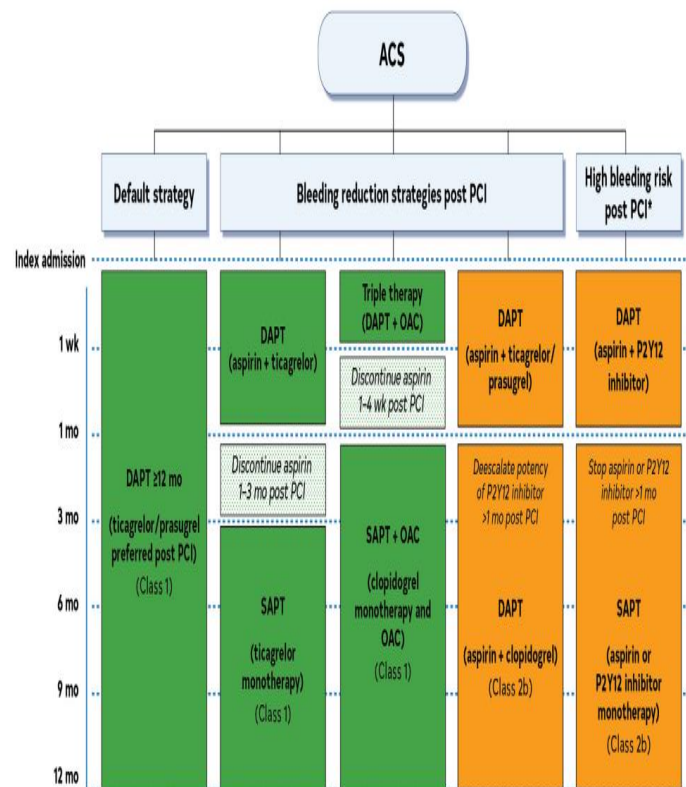


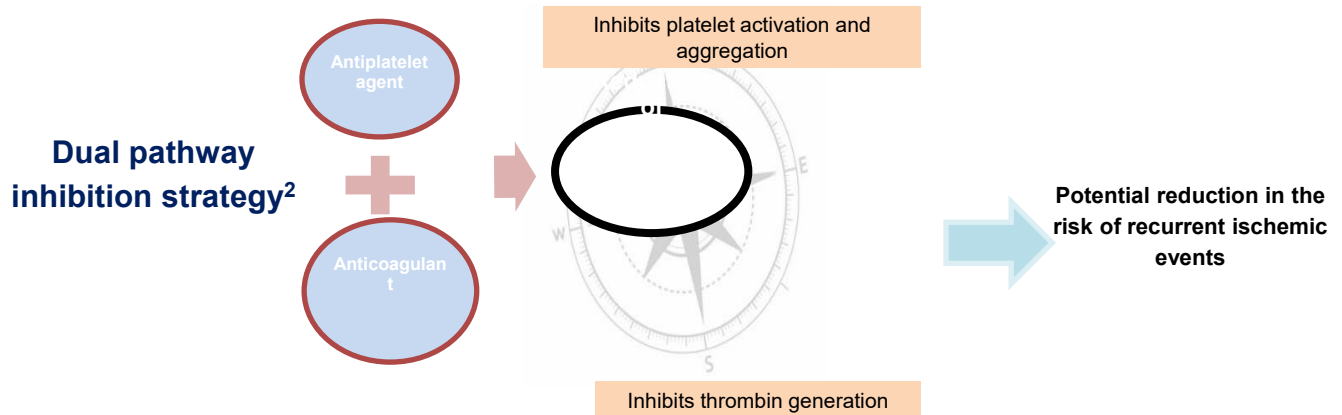
FIGURE 11 DAPT Strategies in the First 12 Months Postdischarge



Colors correspond to Class of Recommendation in Table 2. *High bleeding risk discussed in Section 11.1, "Recommendation-Specific Supportive Text" item 5, and outlined in Table 22. ACS indicates acute coronary syndromes; DAPT, dual antiplatelet therapy; OAC, oral anticoagulant; PCI, percutaneous coronary intervention; and SAPT, single antiplatelet therapy.

Suitable therapeutic option for reduction of thrombosis in CAD patients

Prevalence of ischemic events remains high despite using effective single or dual antiplatelets¹



Dagrafors01

Dapagliflozin je terapija srčane insuficijencije čija korist nadilazi kontrolu glikemije — smanjuje rizik od pogoršanja HF kroz širok spektar LVEF i nezavisno od prisustva dijabetesa.

Xerdoxo02

Kod odgovarajućeg bolesnika sa AF, pravilno odabran i doziran DOAC predstavlja standardnu strategiju dugoročne prevencije tromboembolijskog moždanog udara.

**„U kardiologiji,
uspjeh nije samo
ono što liječimo
danas, već i ono što
spriječimo sutra.“**

