Quoi de Neuf ?

En Prévention cardiovasculaire

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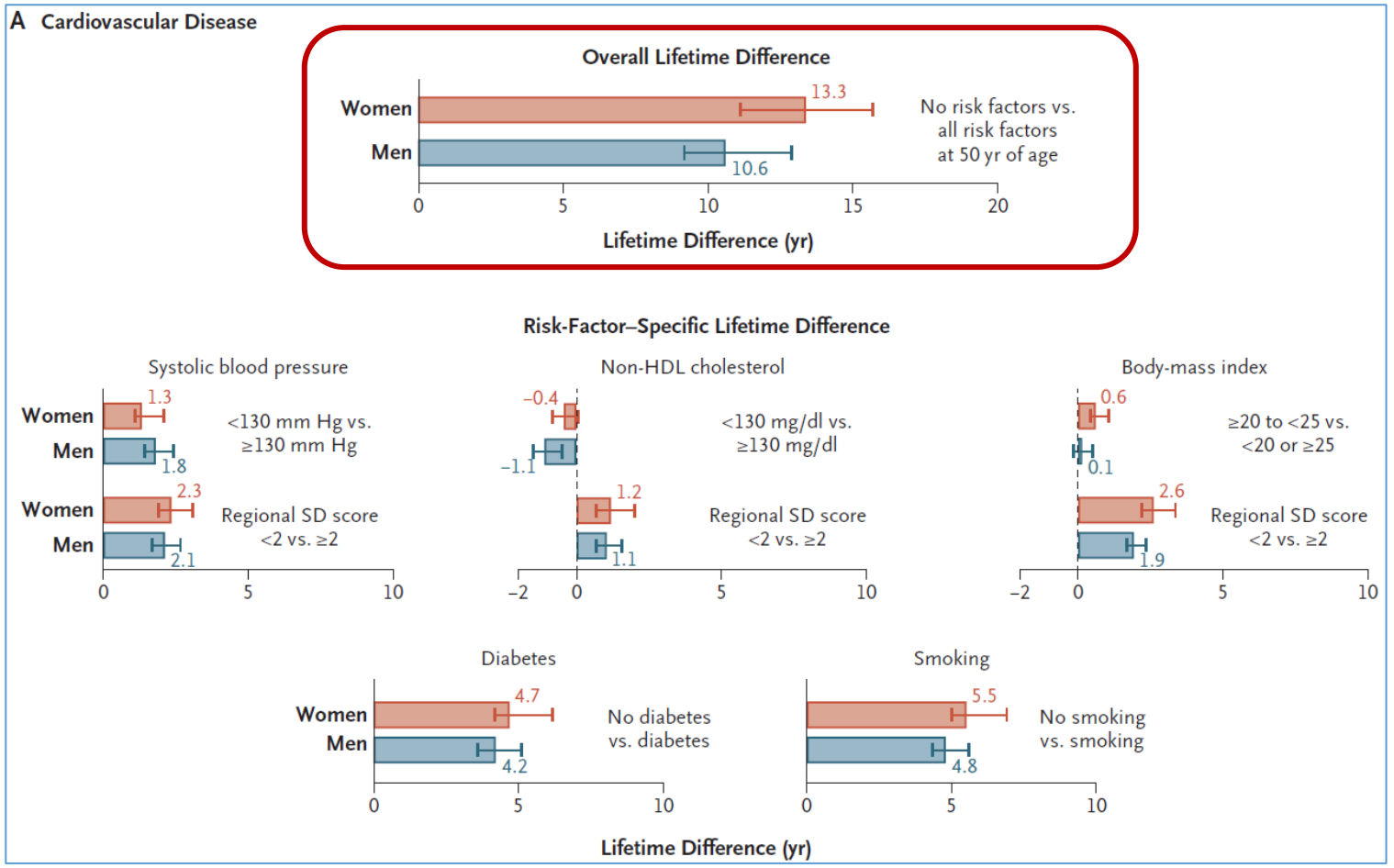
Conflits d’intérêts

Je déclare les liens d'intérêt potentiels (interventions ponctuelles, recherche) avec les sociétés suivantes au cours des 3 dernières années:

Amarin, Amgen, MSD, NovoNordisk, Novartis, Sanofi, Viatris

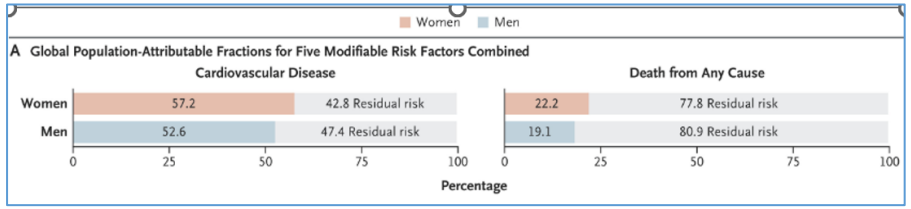
Prévention Cardiovasculaire Globale

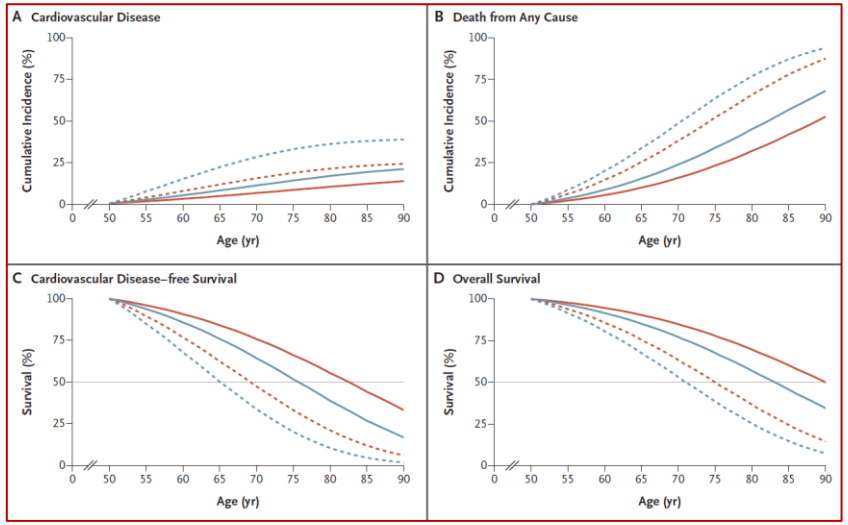
Différence d'espérance de vie selon l'absence vs présence des 5 FDR cardiovasculaires à l'âge de 50 ans: 13,3 ans (F) et 10,6 ans (H)



- 2 078 948 participants
- 133 cohortes

➢ **5 FDR expliquent 57 et 53% des MCV**





Global Effect of Cardiovascular Risk Factors on Lifetime Estimates , NEJM 2025

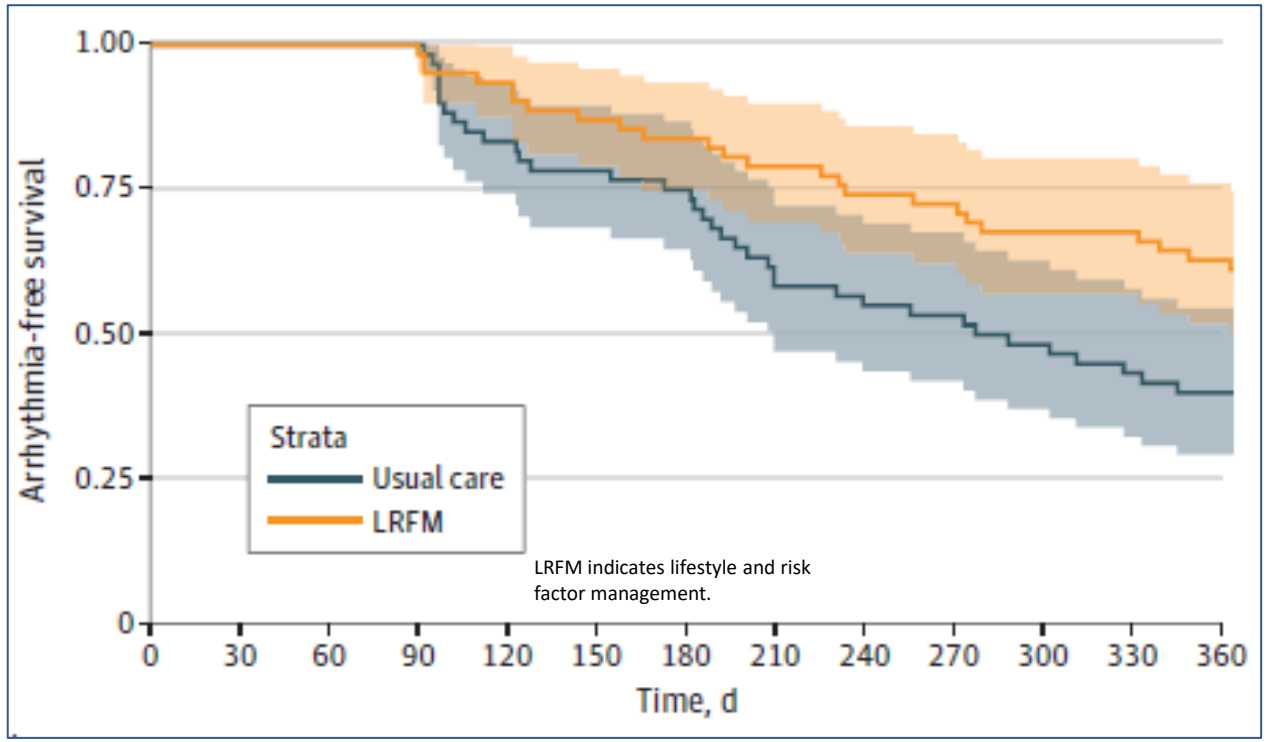
La prise en charge active des facteurs de risque réduit de 47% le risque de récidive de FA après procedure d'ablation

The ARREST-AF Randomized Clinical Trial

- BMI > 27 + 1 risk factor
- N= 62 (aggresive) vs 60 (usual care)
- Aggressive: Lifestyle (tabac, OH, poids, exercice), RF Control, Sleep-disorder mgt

Measure	Group	Mean (SD)		Mean between-group difference at 12-mo (95% CI)[a]
		Baseline	12 mo	
Cardiometabolic risk factors				
Body weight, kg	LRFM	99.2 (14.5)	90.2 (13.3)	−9.0 (−11.1 to −6.8)
	Usual care	103.0 (19.2)	102.9 (21.8)	
Waist circumference, cm	LRFM	106.6 (10.9)	99.3 (11.2)	−7.0 (−9.4 to −4.5)
	Usual care	109.3 (13.6)	108.9 (15.2)	
Systolic blood pressure, mm Hg	LRFM	137.6 (13.9)	124.5 (15.6)	−10.8 (−16.1 to −5.5)
	Usual care	127.8 (13.9)	131.7 (13.8)	
Diastolic blood pressure, mm Hg	LRFM	81.8 (10.7)	75.9 (9.5)	−3.5 (−7.2 to 0.2)
	Usual care	75.0 (8.1)	78.2 (10.2)	
Fasting plasma glucose, mg/dL	LRFM	99.1 (21.6)	95.5 (16.2)	−3.6 (−9.0 to 1.8)
	Usual care	108.1 (34.2)	104.5 (32.4)	
Total cholesterol, mg/dL	LRFM	177.6 (38.6)	177.6 (38.6)	0 (−11.6 to 11.6)
	Usual care	181.5 (42.5)	177.6 (34.7)	
Low-density lipoprotein, mg/dL	LRFM	100.4 (34.7)	100.4 (30.9)	0 (−7.7 to 11.6)
	Usual care	108.1 (34.7)	100.4 (34.7)	
Triglycerides, mg/dL	LRFM	132.7 (79.6)	115.0 (53.1)	−8.6 (−26.6 to 17.7)
	Usual care	123.9 (53.1)	115.0 (79.6)	
Exercise capacity, METs	LRFM	7.9 (2.4)	8.9 (2.4)	0.9 (0.3 to 1.5)
	Usual care	7.8 (2.3)	8.0 (2.1)	

Arrhythmia-Free Survival Up to 12 Months After Catheter Ablation



Pathak RK, JAMA Cardiol oct 2025

Le THS ne majore pas le risque CV < 60 ans mais le majore nettement après 70

Etude WHI (27 347 participantes US)

OG seuls

Subgroup	Patients in the CEE alone trial, No. (annualized %) HT	Placebo	Difference in absolute risk per 10 000 PY	P value[a]
Main effect	704 (1.98)	658 (1.79)	19	.07
Moderate or severe VMS				
No	567 (1.95)	540 (1.80)	15	.37
Yes	129 (2.14)	108 (1.73)	40	
Age at randomization, y				
50–59	98 (0.82)	119 (0.98)	-16	.10
60-69	348 (2.23)	307 (1.88)	35	
70-79	258 (3.22)	232 (2.82)	40	
Time since menopause, y[b]				
<10	55 (0.87)	52 (0.83)	4	.87
10 to <20	201 (1.70)	172 (1.41)	29	
≥20	448 (2.58)	435 (2.37)	21	
VMS by age, y				
No				
50-59	64 (0.75)	78 (0.89)	-14	.31
60-69	278 (2.09)	252 (1.81)	27	
70-79	225 (3.11)	210 (2.84)	27	
Yes				
50-59	34 (1.04)	38 (1.17)	-13	.03
60-69	64 (3.00)	52 (2.26)	74	
70-79	31 (4.77)	18 (2.60)	217	

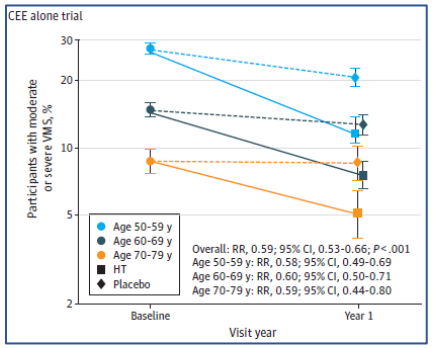
Favors HT | Favors placebo

OG + PG

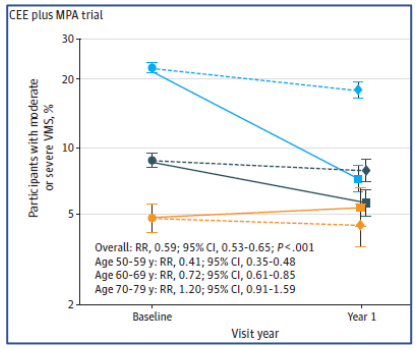
Patients in the CEE plus MPA trial, No. (annualized %) HT	Placebo	Difference in absolute risk per 10 000 PY	P value[a]
573 (1.22)	534 (1.21)	1	.74
495 (1.22)	462 (1.21)	1	.69
71 (1.20)	59 (1.10)	10	
86 (0.52)	83 (0.53)	-2	.59
266 (1.28)	251 (1.29)	-1	
221 (2.39)	200 (2.23)	15	
104 (0.58)	103 (0.62)	-4	.49
238 (1.28)	225 (1.29)	-1	
231 (2.22)	207 (2.07)	15	
64 (0.50)	60 (0.50)	0	.76
232 (1.23)	212 (1.20)	4	
199 (2.26)	190 (2.25)	0	
20 (0.54)	20 (0.60)	-6	.02
30 (1.64)	32 (2.04)	-40	
21 (5.44)	7 (1.62)	382	

Favors HT | Favors placebo

MACE



Effet sur les Tb vasomoteurs



Rossouw JE, JAMA Intern Med 2025;185(11):1330-1339

Pas d'évidence de surmortalité (globale/CV) avec le THS

Cohorte danoise (876805 F > 45 ans, dont 104086 avec THS)

Table 2 | Association between menopausal hormone therapy and all cause mortality

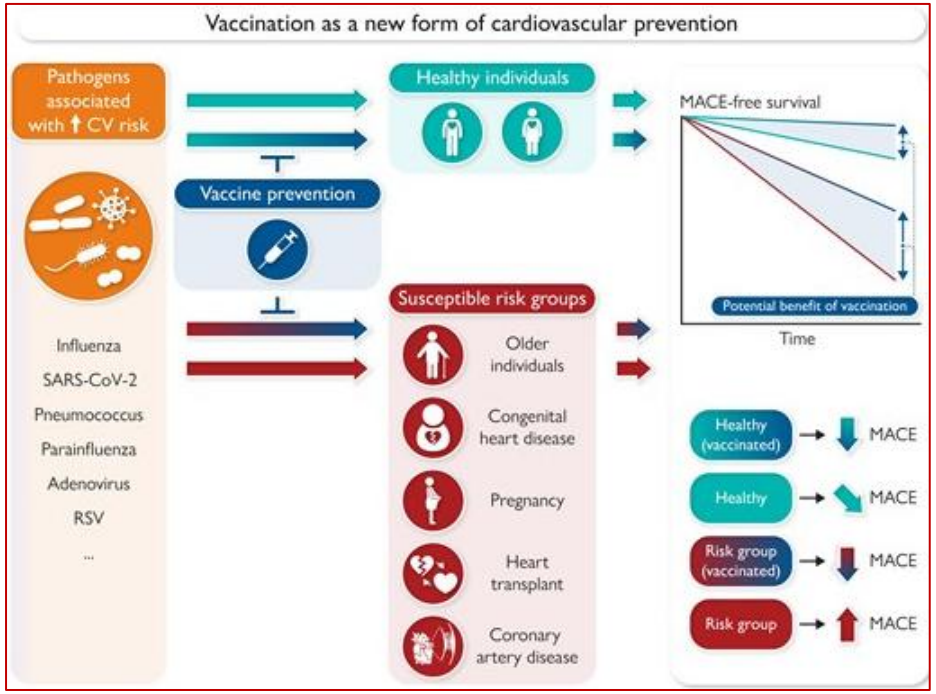
Years of MHT use	No of mortality events	No of person years	IR*	Crude HR (95% CI)	Adjusted HR (95% CI)†
Primary analysis					
Never used	40 033	11 285 883	35.5	1	1
Past or present use	7561	1 377 023	54.9	1.04 (1.01 to 1.06)	0.96 (0.93 to 0.98)
Primary analysis stratified by duration of use					
0 years	40 033	11 285 883	35.5	1	1
<1 year	3107	569 091	54.6	1.12 (1.08 to 1.16)	1.01 (0.98 to 1.05)
1-2.9 years	1804	369 244	48.9	0.98 (0.93 to 1.03)	0.94 (0.89 to 0.98)
3-4.9 years	979	190 191	51.5	0.94 (0.88 to 1.00)	0.90 (0.84 to 0.95)
5-9.9 years	1120	186 955	59.9	0.98 (0.92 to 1.04)	0.89 (0.84 to 0.95)
≥10 years	551	61 542	89.5	1.12 (1.03 to 1.22)	0.98 (0.90 to 1.07)
Stratified analysis: by treatment form most used					
Never used	40 033	11 285 883	35.5	1	1
Oral	6457	1 119 600	57.7	1.08 (1.05 to 1.11)	0.98 (0.95 to 1.01)
Transdermal	1098	256 122	42.9	0.85 (0.80 to 0.90)	0.85 (0.80 to 0.90)
Other formulation	6	1302	46.1	0.81 (0.36 to 1.79)	0.68 (0.30 to 1.50)

Table 3 | Association between menopausal hormone therapy and cause-specific mortality

Years of MHT use	No of mortality events	No of person years	IR*	Crude HR (95% CI)	Adjusted HR (95% CI)
Cardiovascular mortality†					
0 years	4495	10 919 435	4.1	1	1
<5 years	570	1 086 597	5.2	0.91 (0.83 to 0.99)	0.84 (0.77 to 0.92)
≥5 years	180	236 475	7.6	0.99 (0.85 to 1.15)	0.91 (0.78 to 1.05)
Cancer mortality‡					
0 years	18 145	10 919 435	16.6	1	1
<5 years	2873	1 086 597	26.4	1.11 (1.06 to 1.15)	1.04 (1.00 to 1.09)
≥5 years	781	236 475	33.0	1.05 (0.98 to 1.13)	0.98 (0.91 to 1.05)
Other mortality‡					
0 years	15 310	10 919 435	14.0	1	1
<5 years	2152	1 086 597	19.8	1.01 (0.97 to 1.06)	0.88 (0.67 to 1.15)
≥5 years	597	236 475	25.2	0.98 (0.90 to 1.07)	0.72 (0.48 to 1.07)

Mikkelsen, BMJ 2026

Consensus ESC sur la vaccination en tant que modalité de prévention cardiovasculaire



Recommendations	Class	Level
Imaging		
In patients with pre-discharge LVEF ≤40%, repeat evaluation of the LVEF 6–12 weeks after an ACS (and after complete revascularization and the institution of optimal medical therapy) is recommended to assess the potential need for sudden cardiac death primary prevention ICD implantation.	I	C
Cardiac magnetic resonance imaging should be considered as an adjunctive imaging modality in order to assess the potential need for primary prevention ICD implantation.	IIa	C
Vaccination		
Influenza vaccination is recommended for all ACS patients.	I	A
Anti-inflammatory drugs		
Low-dose colchicine (0.5 mg once daily) may be considered, particularly if other risk factors are insufficiently controlled or if recurrent cardiovascular disease events occur under optimal therapy.	IIb	A

Table 2 When to vaccinate? Patients with chronic cardiovascular disease, heart failure and coronary artery disease

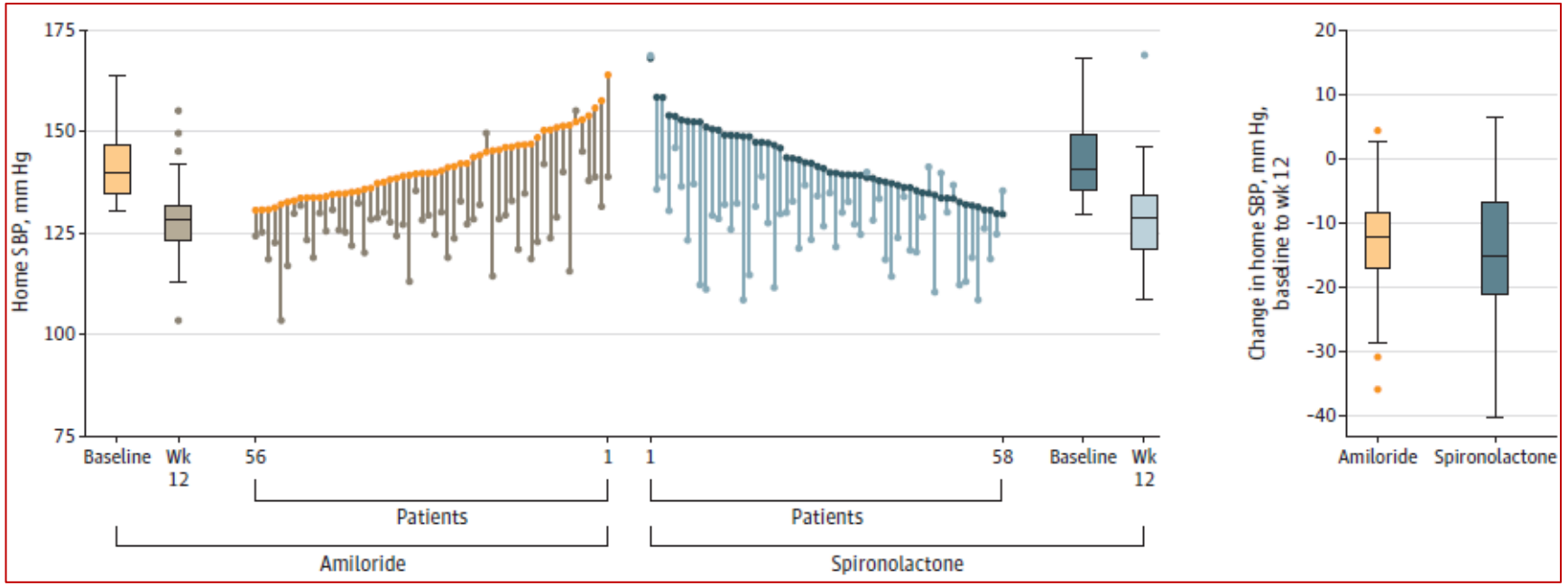
Pathogen	Before winter, annually	Specific pluriannual schedule	Possible in acute conditions (e.g. acute HF)	Possibility of simultaneous vaccination
Influenza	X		X	X
Pneumococcus		X 5–10 years	X	X
COVID-19	?		X	X
RSV	?	2 years?	?	X
Herpes zoster		X		
DT-polio		X[a]		

Heidecker, EHJ 2025

Hypertension artérielle

Amiloride ou Spironolactone dans l'HTA ?

- Pts with a resistant hypertension defined as daytime mean SBP > 130mmHg on a 24-hour ABP and office SBP of 130 to 180mmHg despite taking 3 or more antihypertensive medications (ARA blocker, calcium channel blocker, and thiazide)
- Randomized in a 1:1 ratio to receive 12.5 mg/d of spironolactone (n = 60) or 5 mg/d of amiloride (n = 58); if needed (at 4 weeks) 25 mg S (48%) or 10 mg A (31%).



Mean change Wk 12
(Home SBP)

- Spiro – 14,7 mmHg
- Amil – 13,6 mmHg

➢ **Amiloride non-inferior**

Lee CJ, JAMA 2025;333;(23):2073-2082

Un nouvel ARNi-anti angiotensinogène (Zilbesiran) dans l'HTA

- KARDIA-2 Study
- HTA non traitée 155-180 mmHg
- Indapamide 2.5 (n=130) ou AmloD 5 (n=240) ou Olmesartan 40 (n=293)

+ Zilbesiran 600 mg (injection unique) vs Placebo

- Variations de PAS à 3 mois

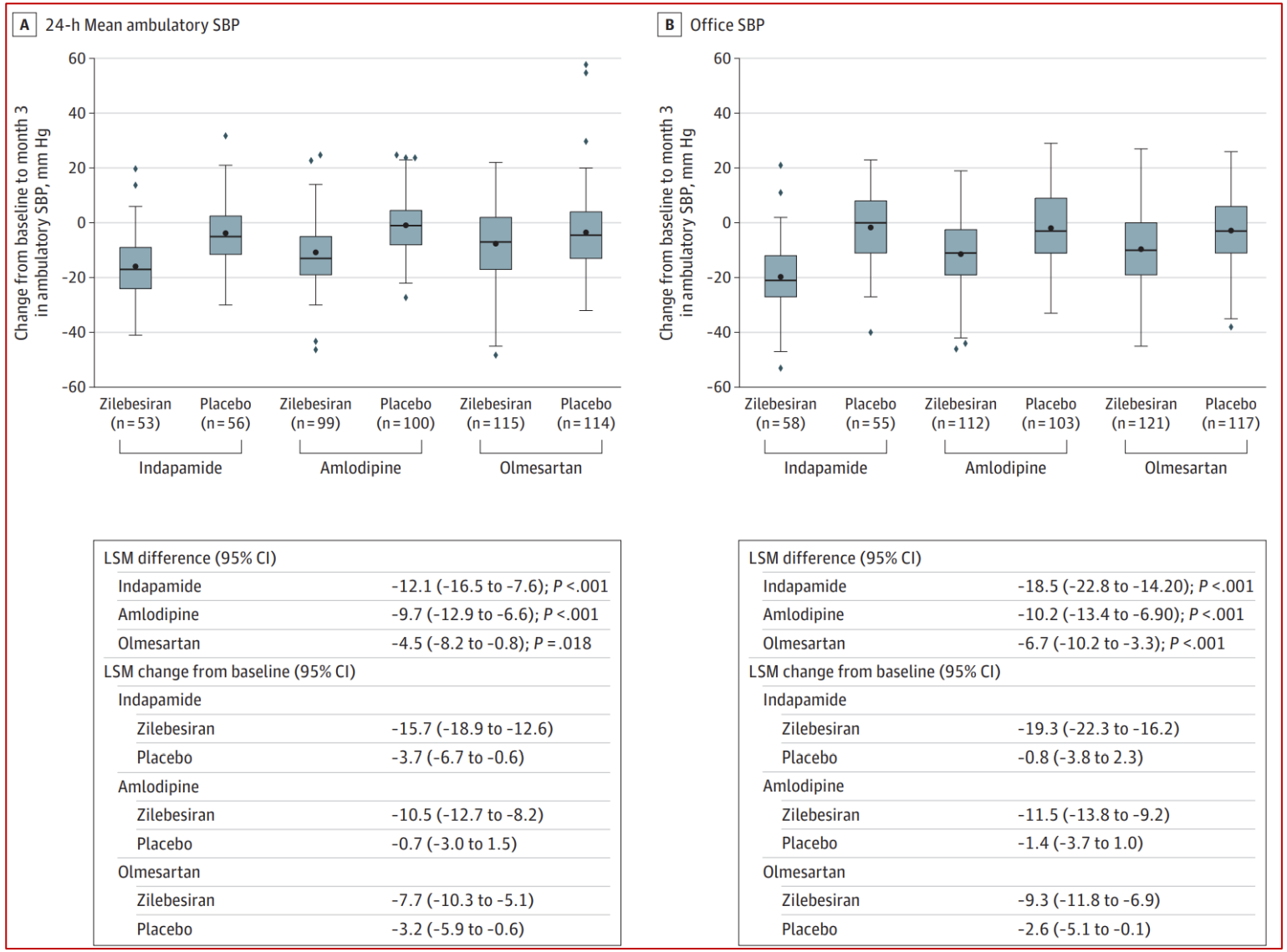
➢ **PAS MAPA 24h à 3 mois:**

- 12.1 mm Hg (indapamide)
- 9.7 mm Hg (amlodipine)
- 4.5 mmHg (Olmesartan)

Desai AS: JAMA mai 2025;334;(1):46-55

NB: ESC 2025: KARDIA-3

➢ Essai negatif (-5 mmHg, ns) mais pts en majorité sous IEC/ARA2



LSM difference (95% CI)	
Indapamide	-12.1 (-16.5 to -7.6); *P* <.001
Amlodipine	-9.7 (-12.9 to -6.6); *P* <.001
Olmesartan	-4.5 (-8.2 to -0.8); *P* = .018
LSM change from baseline (95% CI)	
Indapamide	
Zilebesiran	-15.7 (-18.9 to -12.6)
Placebo	-3.7 (-6.7 to -0.6)
Amlodipine	
Zilebesiran	-10.5 (-12.7 to -8.2)
Placebo	-0.7 (-3.0 to 1.5)
Olmesartan	
Zilebesiran	-7.7 (-10.3 to -5.1)
Placebo	-3.2 (-5.9 to -0.6)

LSM difference (95% CI)	
Indapamide	-18.5 (-22.8 to -14.20); *P* <.001
Amlodipine	-10.2 (-13.4 to -6.90); *P* <.001
Olmesartan	-6.7 (-10.2 to -3.3); *P* <.001
LSM change from baseline (95% CI)	
Indapamide	
Zilebesiran	-19.3 (-22.3 to -16.2)
Placebo	-0.8 (-3.8 to 2.3)
Amlodipine	
Zilebesiran	-11.5 (-13.8 to -9.2)
Placebo	-1.4 (-3.7 to 1.0)
Olmesartan	
Zilebesiran	-9.3 (-11.8 to -6.9)
Placebo	-2.6 (-5.1 to -0.1)

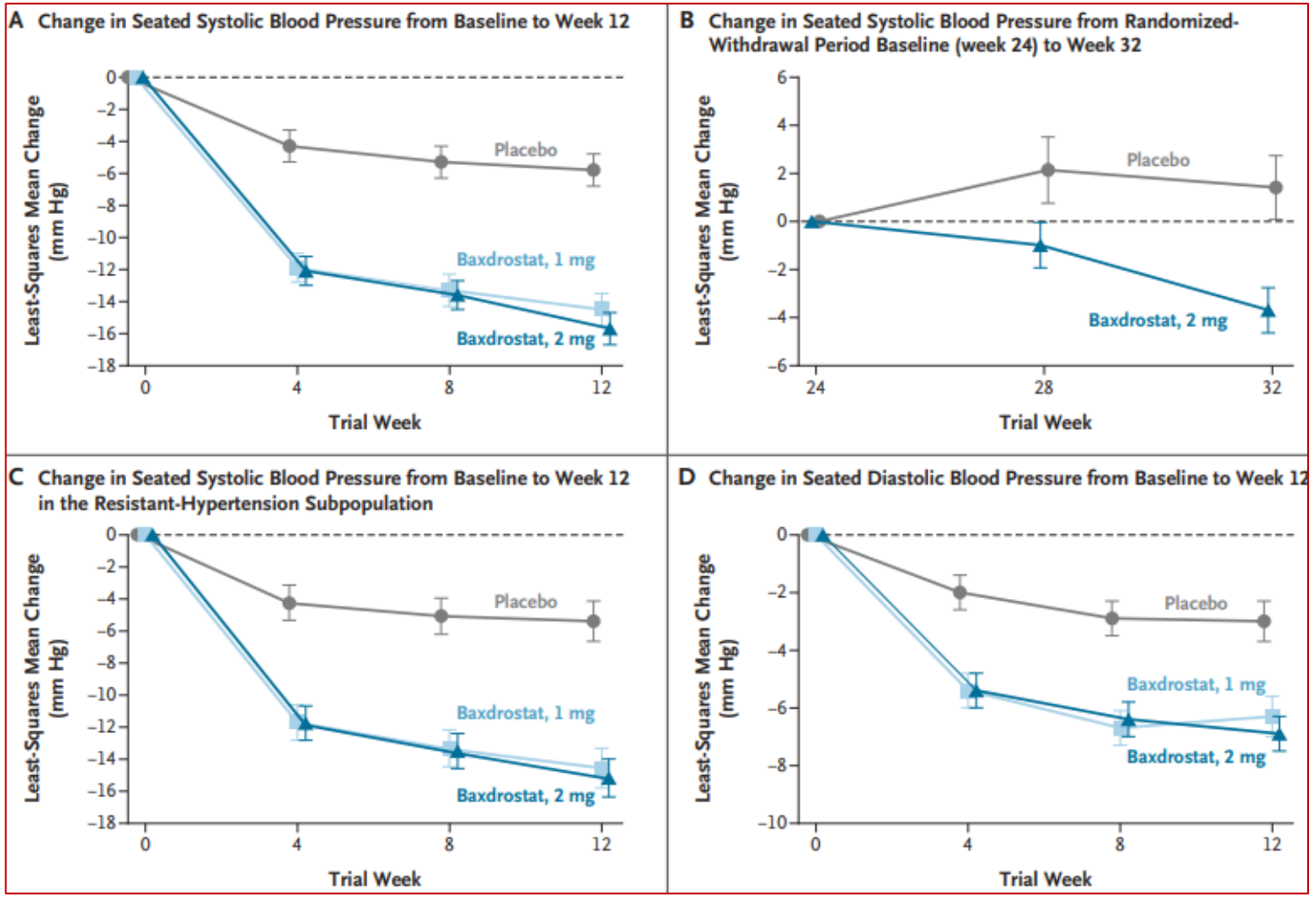
Évaluation de l'effet du Baxdrostat, inhibiteur de la synthèse de l'aldostérone, dans l'hypertension artérielle non contrôlée ou résistante

- 794 Pts with uncontrolled (2 antiHT) or resistant (3 antiHT) HBP (SBP 140-170 mmHg)
- 90% IEC/ARA2 et 99% diuretiques
- Randomisation 1:1:1 entre **Baxdrostat** 1mg vs 2 mg vs placebo
- Baxdrostat = aldosterone synthase inhibitor

➢ **Pourcentage de sujets avec PAS contrôlée (< 130) :**

- 39 % (Bax 1mg),
- 40 % (Bax 2 mg)
- et 19 % (placebo)
- OR= 2,9; PR < 0,001

Flack, NEJM 08/2025 et ESC 2025



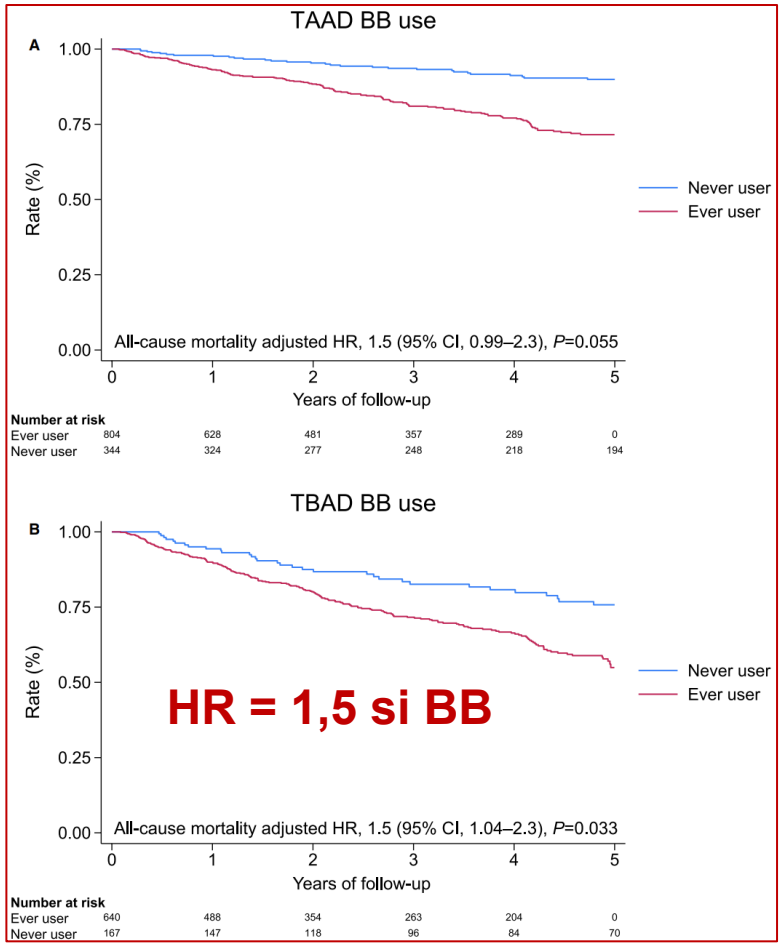
L'usage de beta-bloquants dans l'HTA majore le risque de dissections de l'aorte et la survie après dissection

- Cohorte danoise cas-contrôle 1657 dissections vs 16139 contrôles HT appariés (observationnel)
- BB # 43% des sujets
- **Prévention primaire:**
  - **Risque de DAo associé à l'usage de BB vs noBB:**
    - Type A: OR = 1,7 (1,3-2,3)
    - Type B: OR = 3,7 (2,7-5,2)

	Aortic Dissection Type A				Aortic Dissection Type B			
	Cases	**Controls**	**Crude OR (95% CI)**	**Adjusted OR* (95% CI)**	**Cases**	**Controls**	**Crude OR (95% CI)**	**Adjusted OR* (95% CI)**
Use of Beta-Blockers 1996-2006	N= 117	N =1,201			N=88	N= 830		
Never	52 (44.4)	589 (49.0)	1.0 (ref)	1.0 (ref)	25 (28.4)	448 (54.0)	1.0 (ref)	1.0 (ref)
Long-term[A]	65 (55.6)	612 (51.0)	1.2 (0.8-1.8)	1.2 (0.7-2.1)	63 (71.6)	382 (46.0)	2.9 (1.8-5.0)	3.3 (1.7-6.6)
Use of Beta-Blockers 2007-2016	N= 317	N = 4,097			N=242	N= 3,430		
Never	157 (49.5)	2,681 (65.4)	1.0 (ref)	1.0 (ref)	78 (32.2)	2,146 (62.6)	1.0 (ref)	1.0 (ref)
Long-term[A]	160 (50.5)	1,416 (34.6)	1.9 (1.5-2.4)	1.9 (1.4-2.7)	164 (67.8)	1,284 (37.4)	3.5 (2.6-4.7)	3.8 (2.7-5.6)

Liisberg: J Am Heart Assoc. 2025;14:e040149

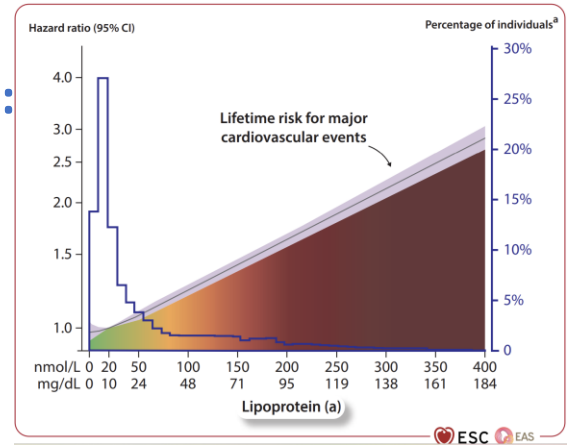
MORTALITE à 5 ans après DAo



Lipides

Update Guidelines ESC Lipids 2025

➢ Lp(a):



Recommendations	Class[a]	Level[b]
Lp(a) levels above 50 mg/dL (105 nmol/L) should be considered in all adults as a CV risk-enhancing factor, with higher Lp(a) levels associated with a greater increase in risk.[37,101]	IIa	B

- Un dosage recommandé chez tout adulte, en particulier en cas d'antécédent personnel ou familial d'athérothrombose prématurée
- *https://www.lpaclinicalguidance.com/*

➢ HIV

Recommendation	Class[a]	Level[b]
Statin therapy is recommended for people in primary prevention aged ≥40 years with HIV, irrespective of estimated cardiovascular risk and LDL-C levels, to reduce the risk of cardiovascular events; the choice of statin should be based on potential drug interactions.[7]	I	B

➢ étude REPRIEVE
Pitavastatine 4 mg vs placebo :
HR = 0,65 (0,48 – 0,90, P =.002)

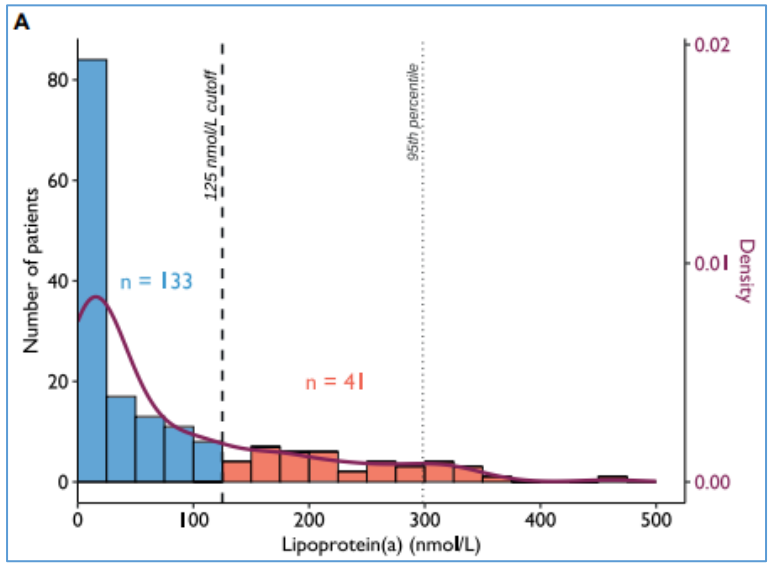
➢ Cancer avec anthracycline

Recommendation	Class[a]	Level[b]
Statins should be considered in adult patients at high or very high risk of developing chemotherapy-related cardiovascular toxicity[c] to reduce the risk of anthracycline-induced cardiac dysfunction.[9,132–134]	IIa	B

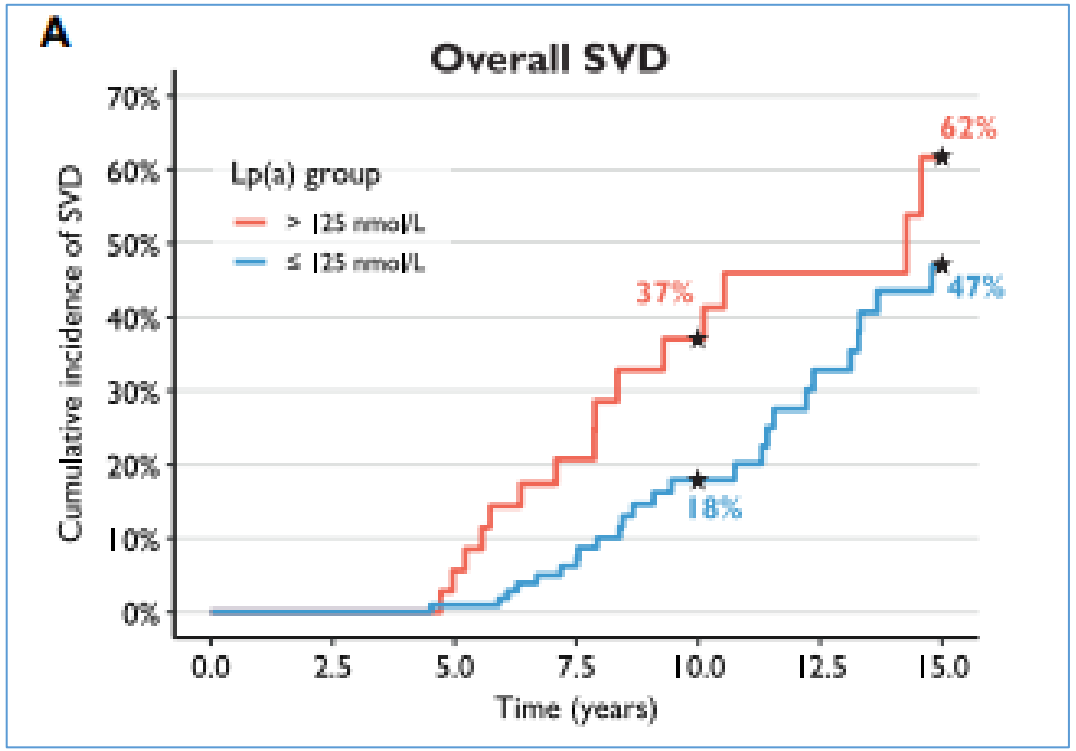
➢ Essai STOP-CA :
3300 pts avec lymphome
Atorva 40 mg vs Placebo
Baisse FEVG ≥10% : 22% vs 9%;
P = .002

Mach F, EHJ 2025

Lp(a) et dégénérescence de bioprothèses valvulaires aortiques



- 174 bioprosthetic AVR patients with available Lp(a) levels over a median echocardiographic follow-up of 7.3 years
- Elevated Lp(a) > 125 nmol/l was associated with a higher risk of overall SVD (62% vs. 47%; SHR 2.06, 1.09–3.91; P = 0.026) and specifically with stenotic/mixed phenotypes (SHR 2.57, 1.26–5.23; P = 0.009).
- Analyse Multivariée: SHR = 3



Boute, EHJ 2026

L'aspirine réduit le risque d'AVC et de sténose valvulaire aortique chez les sujets avec Lp(a) élevée, pas si LDLc seul élevé

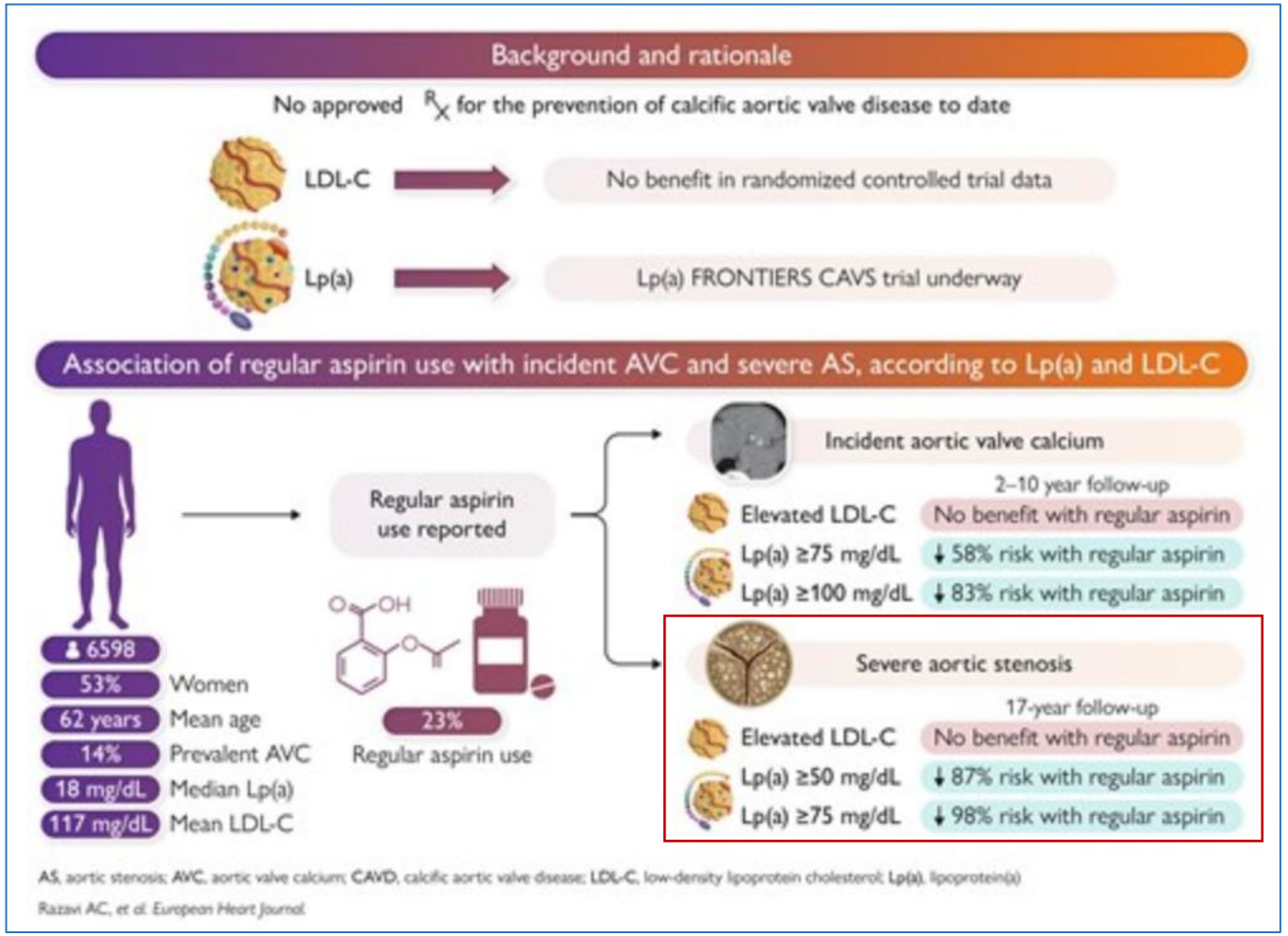
- Etude observationnelle: Cohorte MESA, 6598 sujets
- 23% sous aspirine
- 8% AVC (suivi 8,9 ans)
- 1% de RVAo sévère (suivi 16,7 ans)

➢ **Aspirine réduit le risque AVC**:
  - **Lp(a) ≥ 0,75 g/l**: HR 0,42 (.19–.93)
  - **Lp(a) ≥ 1 g/l**: HR 0,17 (.04–.67)

➢ **Aspirine réduit le risque RVAo sévère**:
  - **Lp(a) ≥ 0,5 g/l**: HR .13 (.04–.47);
  - **Lp(a) ≥ 0,75 g/l**: HR .02 (.001–.29).

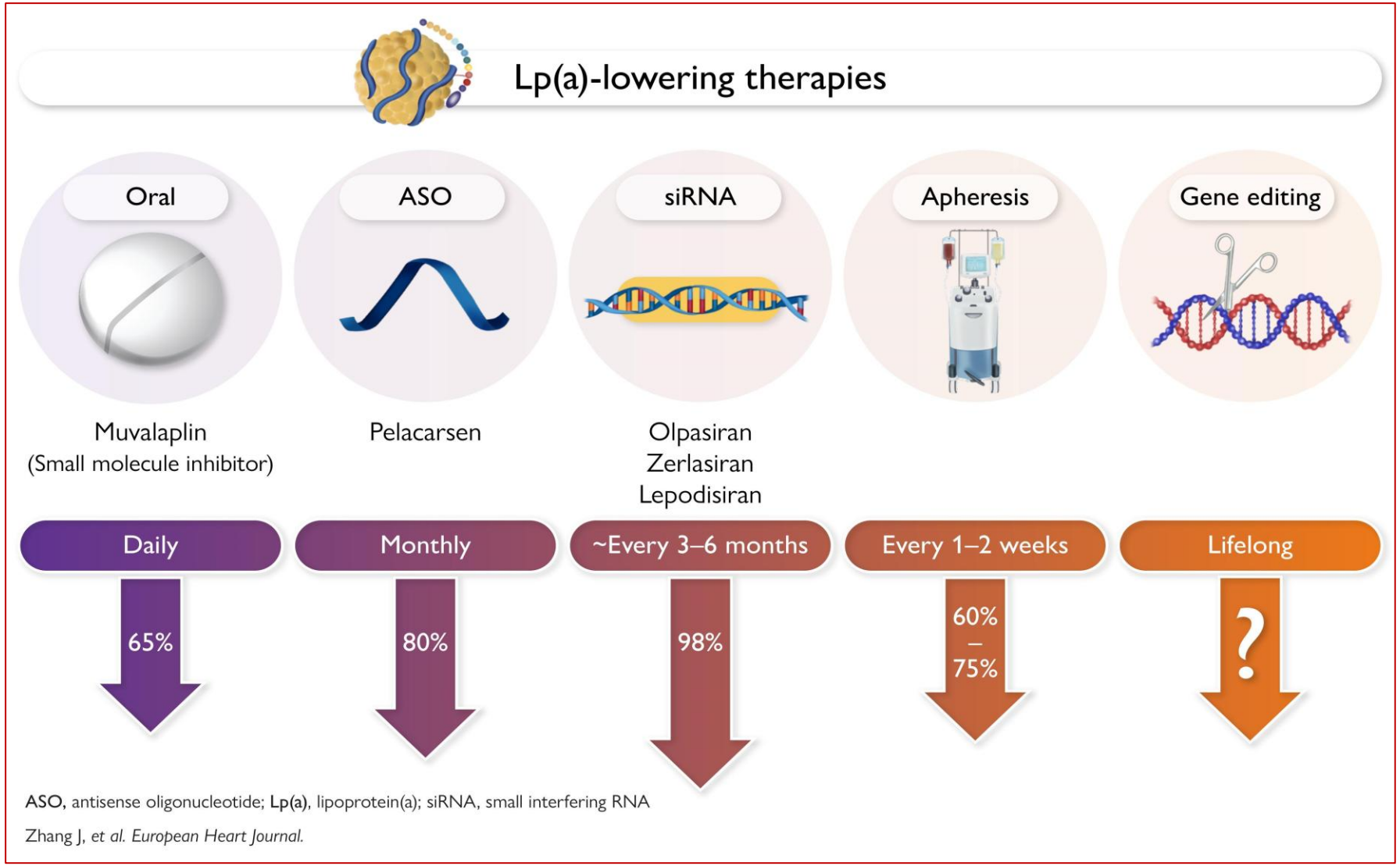
➢ Pas de réduction AVC:
  - LDL-C ≥1,3 g/l: HR 1.02 (.66–1.58);
  - LDL-C ≥1,6 g/l: HR 1.51 (.53–4.28)

➢ Pas de réduction RVAo:
  - LDL-C ≥ 1 g/l: HR .70 (.39–1.26);
  - LDL-C ≥1,3 g/l: HR .46 (.14–1.47)



Razavi, EHJ fév. 2026

Effet de diverses thérapeutiques anti Lp(a) et modes d'administration



Zhang J: Eur Heart J fev 2026, ehag092, https://doi.org/10.1093/eurheartj/ehag092

ESC European Society of Cardiology

Evolocumab (iPCSK9) chez des sujets à haut risque CV (hors SCA, AVC): Vesalius-cv study

Vesalius-cv Trial Design

N= 12,257

Stable patients at high-risk for CV events but no prior MI or stroke*

Event & f/up driven trial:
- 3-P MACE ≥ 751 events
- 4-P MACE ≥ 1,254 events
- Median f/up ≥ 4.5yrs

LDL-C ≥ 90 mg/dL or non-HDL-C ≥ 120 mg/dL or ApoB ≥ 80mg/dL
On optimized statin therapy (± ezetimibe)

*At least one of the following:
- CAD without MI
- CVD without stroke
- PAD
- High-risk diabetes mellitus

1:1 Randomization

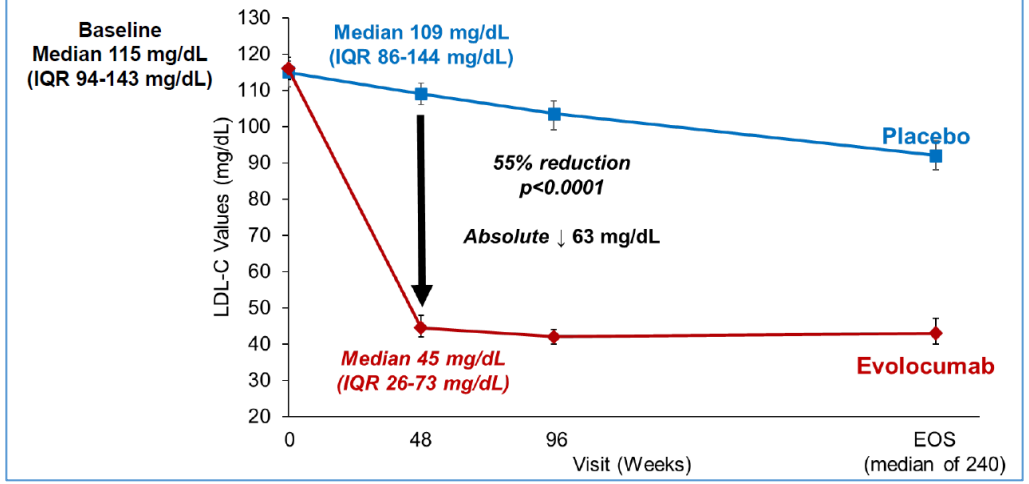
Evolocumab SC 140 mg Q2W

Placebo SC Q2W

Dual Primary Endpoints:
Time to coronary heart disease death, MI, or ischemic stroke (3-P MACE)
Time to 3-P MACE plus ischemia-driven arterial revascularization (4-P MACE)

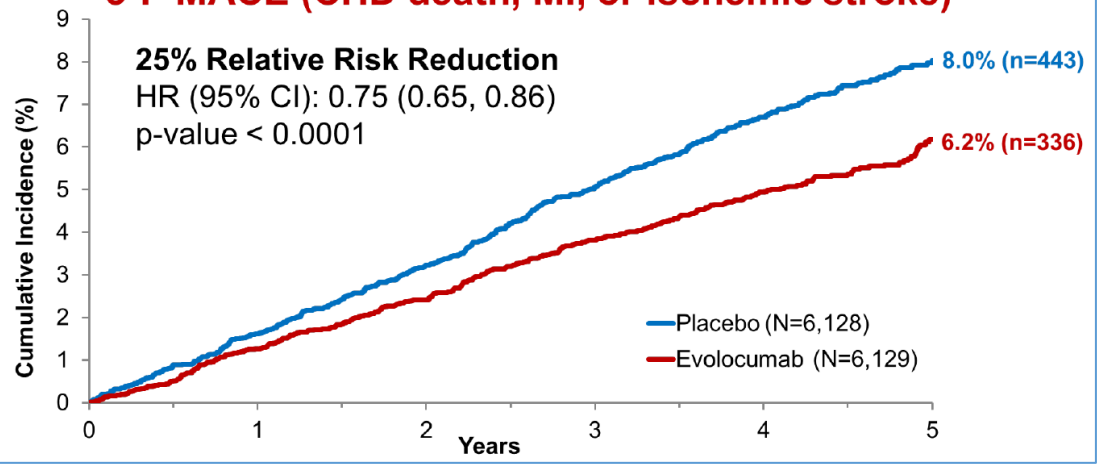
Bohula EA, et al. *Am Heart J.* 2024;269:179-190.

Vesalius-cv LDL-C Over Time



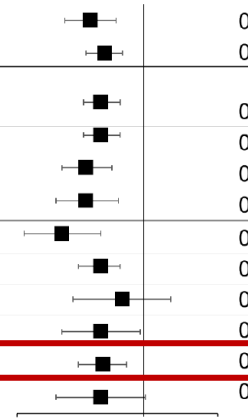
Vesalius-cv Dual Primary Endpoint

3-P MACE (CHD death, MI, or ischemic stroke)



Vesalius-cv Primary & Key Secondary EPs

		HR (95% CI)	p-value
Dual Primary Endpoints			
	3-P MACE	0.75 (0.65, 0.86)	<0.0001
	4-P MACE	0.81 (0.73, 0.89)	<0.0001
Key Secondary Endpoints *(in testing order)*			
Composite Endpoints	MI, ischemic stroke, or IDR	0.79 (0.72, 0.88)	<0.0001
	CHD death, MI, or IDR	0.79 (0.72, 0.88)	<0.0001
	CV death, MI, or ischemic stroke	0.73 (0.64, 0.84)	<0.0001
	CHD death or MI	0.73 (0.62, 0.87)	0.0003
Individual Endpoints	MI	0.64 (0.52, 0.79)	<0.0001
	IDR	0.79 (0.70, 0.88)	<0.0001
	CHD death	0.89 (0.68, 1.16)	0.39
	CV death	0.79 (0.64, 0.98)	0.032*
	All-cause death	0.80 (0.70, 0.91)	0.0005*
	Ischemic stroke	0.79 (0.62, 1.01)	0.062*



*Nominal p-value

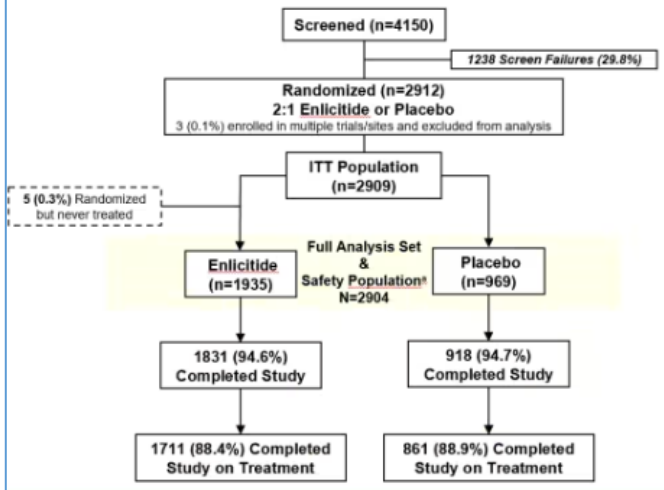
An Academic Research Organization of Brigham and Women's Hospital and Harvard Medical School

CHD, coronary heart disease
IDR, ischemia-driven arterial revasc

Bohula, NEJM 2025

Efficacité d'un inhibiteur PCSK9 par voie orale: Enlicitide

PARTICIPANT DISPOSITION



Reasons for Study Discontinuation[b]

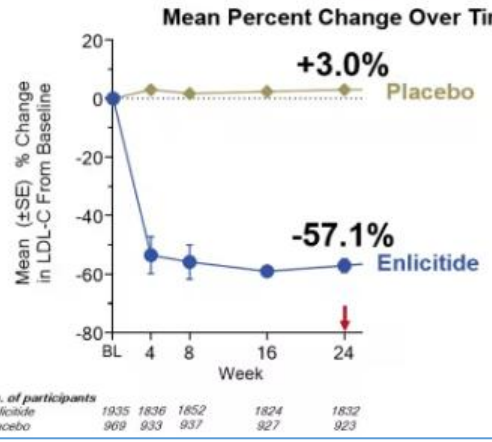
	Enlicitide	Placebo
Total	**109 (5.6%)**	**51 (5.3%)**
Withdrawal By Subject	85 (4.4%)	35 (3.6%)
Death	15 (0.8%)	8 (0.8%)
Lost to Follow Up	3 (0.2%)	2 (0.2%)
Other	2 (0.1%)	5 (0.5%)
Physician Decision	2 (0.1%)	1 (0.1%)
Randomized By Mistake Without Study Treatment	2 (0.1%)	0 (0.0%)

Reasons for Treatment Discontinuation[c]

	Enlicitide	Placebo
Total	**224 (11.6%)**	**108 (11.1%)**
Participant Decision	66 (3.4%)	22 (2.3%)
Withdrawal By Subject	63 (3.3%)	23 (2.4%)
Adverse Event	62 (3.2%)	39 (4.0%)
Death	14 (0.7%)	4 (0.4%)
Non-Compliance with Study Drug	9 (0.5%)	4 (0.4%)
Other	4 (0.2%)	11 (1.1%)
Lost To Follow-Up	3 (0.2%)	2 (0.2%)
Physician Decision	2 (0.1%)	3 (0.3%)
Pregnancy	1 (0.1%)	0 (0.0%)

PRIMARY ENDPOINT: LDL-C REDUCTION AT WEEK 24

Missing Data Handled per SAP[a]



	Enlicitide	Placebo
Baseline (mg/dL)	95.0 *SD 38.8*	98.3 *SD 39.2*
Week 24 (mg/dL)	38.7 *SD 35.6*	98.6 *SD 42.5*
LS Means Between-Group Difference[b]	**-55.8%** (95% CI: -60.9%, -50.7%) *p<0.001*	

Efficacy consistent across prespecified subgroups

Etude Coral Reef Lipids

- 2909 participants
- Enlicitide 20 mg vs placebo

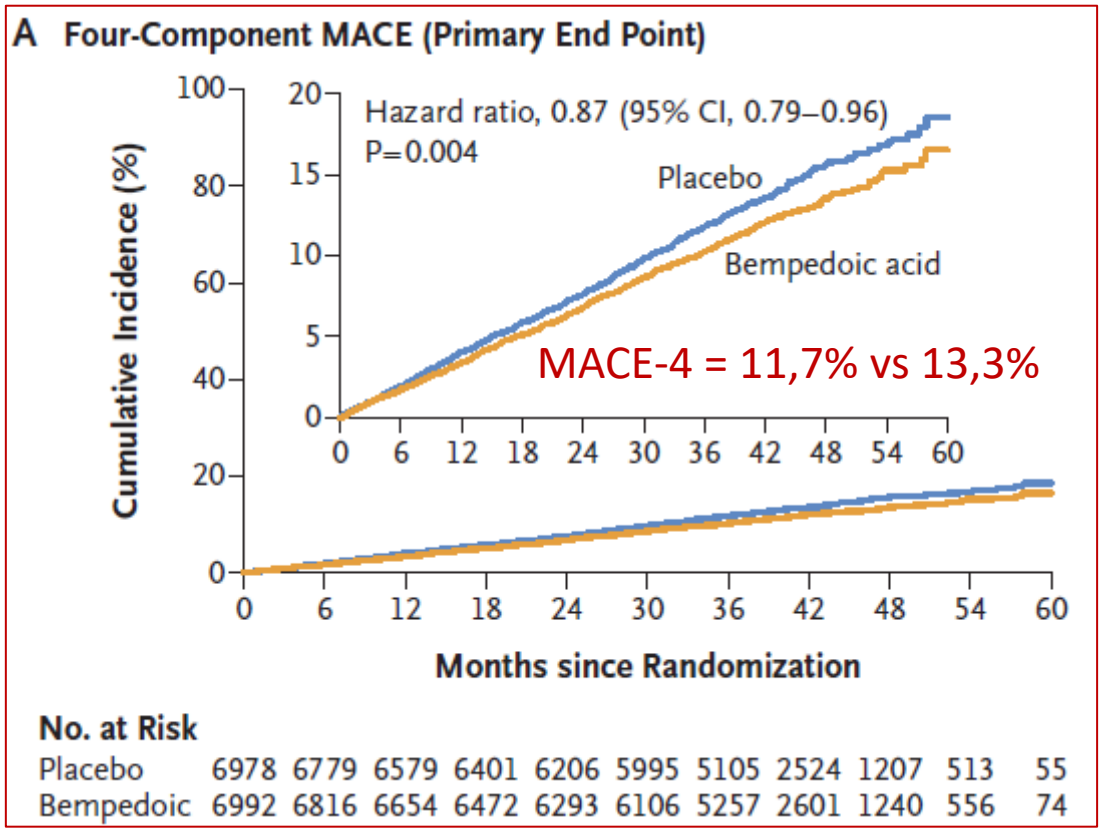
NON-HDL, APOB AND LP(A) AT WEEK 24

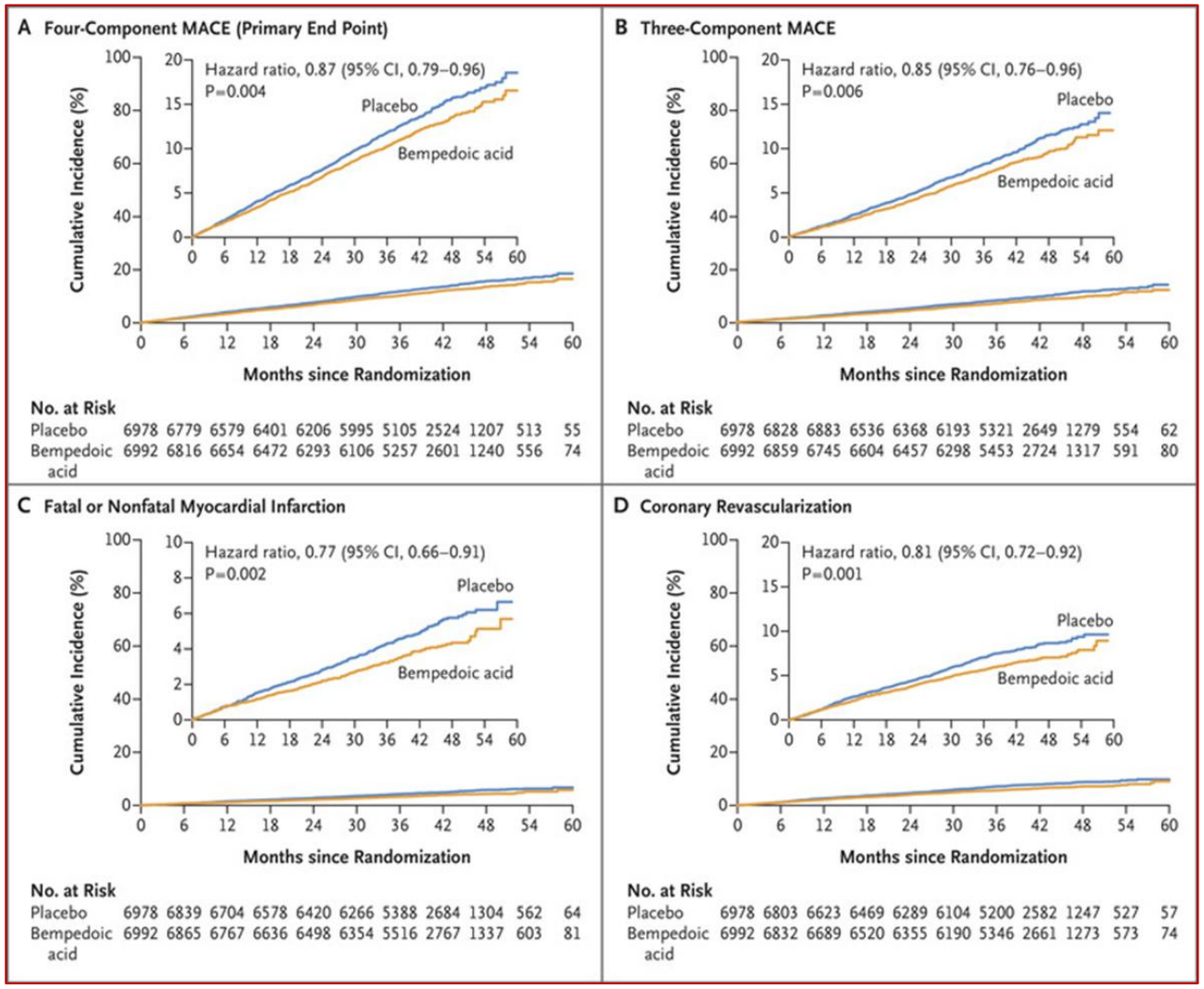
	Enlicitide		Placebo		Between-Group Difference in Percent Change From Baseline (95% CI)
Endpoint[a]	**Mean (SD) or Median (IQR)**	**Percent Change (95% CI or IQR)**	**Mean (SD) or Median (IQR)**	**Percent Change (95% CI or IQR)**	
Non-HDL-C	56.9 (40.4)	-53.7% (-55.0%, -52.5%)	123.5 (47.3)	2.6% (0.8%, 4.5%)	**-53.4%** (-55.5%, -51.2%) p<0.001
ApoB	45.8 (27.4)	-49.6% (-50.8%, -48.5%)	92.6 (30.4)	2.9% (1.3%, 4.4%)	**-50.3%** (-52.1%, -48.5%) p<0.001
Lp(a)	20.8 (6.6 to 95.9)	-29.0% (-50.4% to -7.0%)	33.8 (11.8 to 151.0)	0.0% (-14.9% to 13.3%)	**-28.2%** (-30.3%, -26.0%) p<0.001

Navar, N Engl J Med 2026;394:529-539

Acide Bempédoïque: CLEAR Outcomes trial. MACE

Maintenant Disponible! Décembre 2025



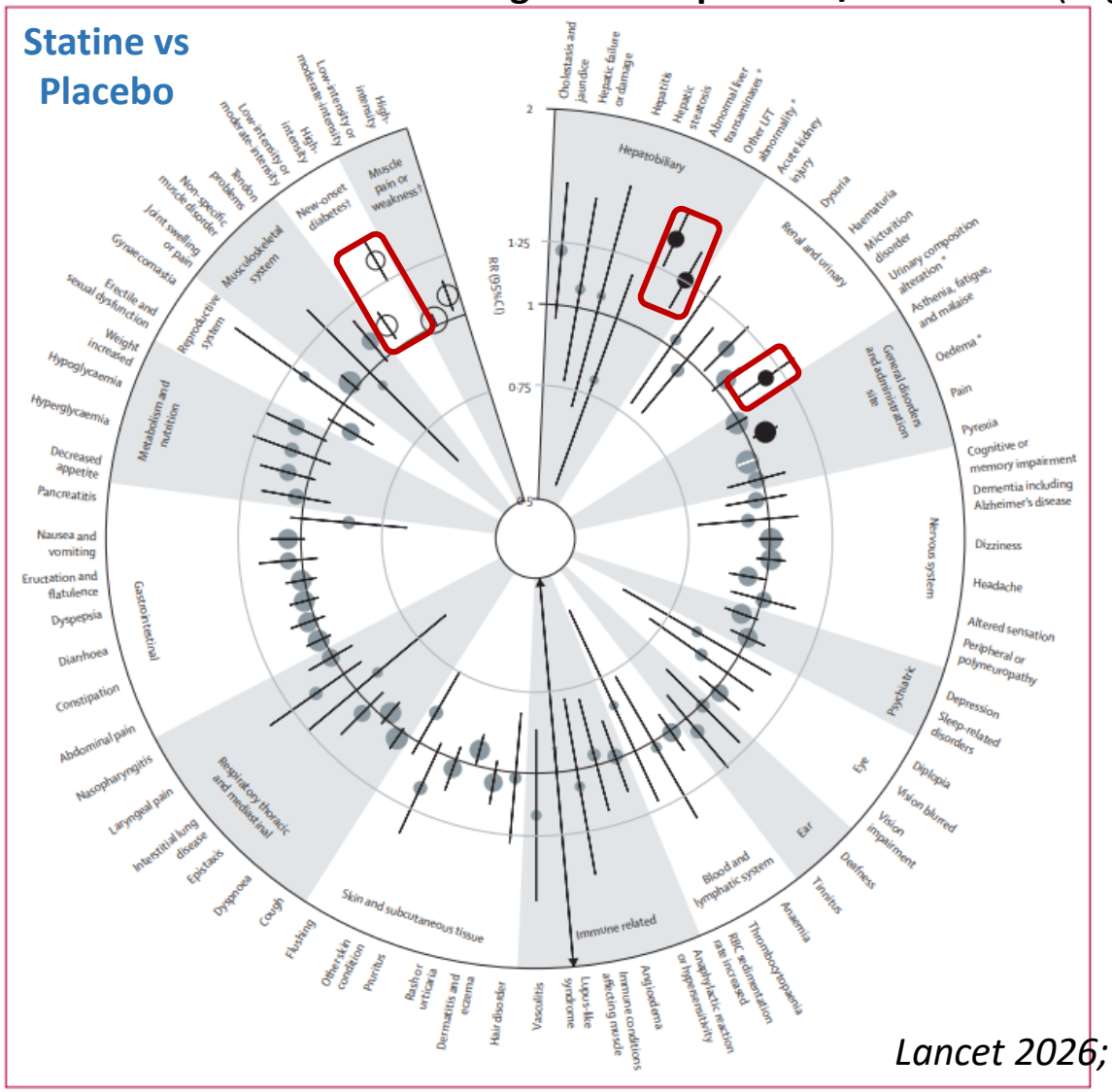


Nissen, NEJM 2023

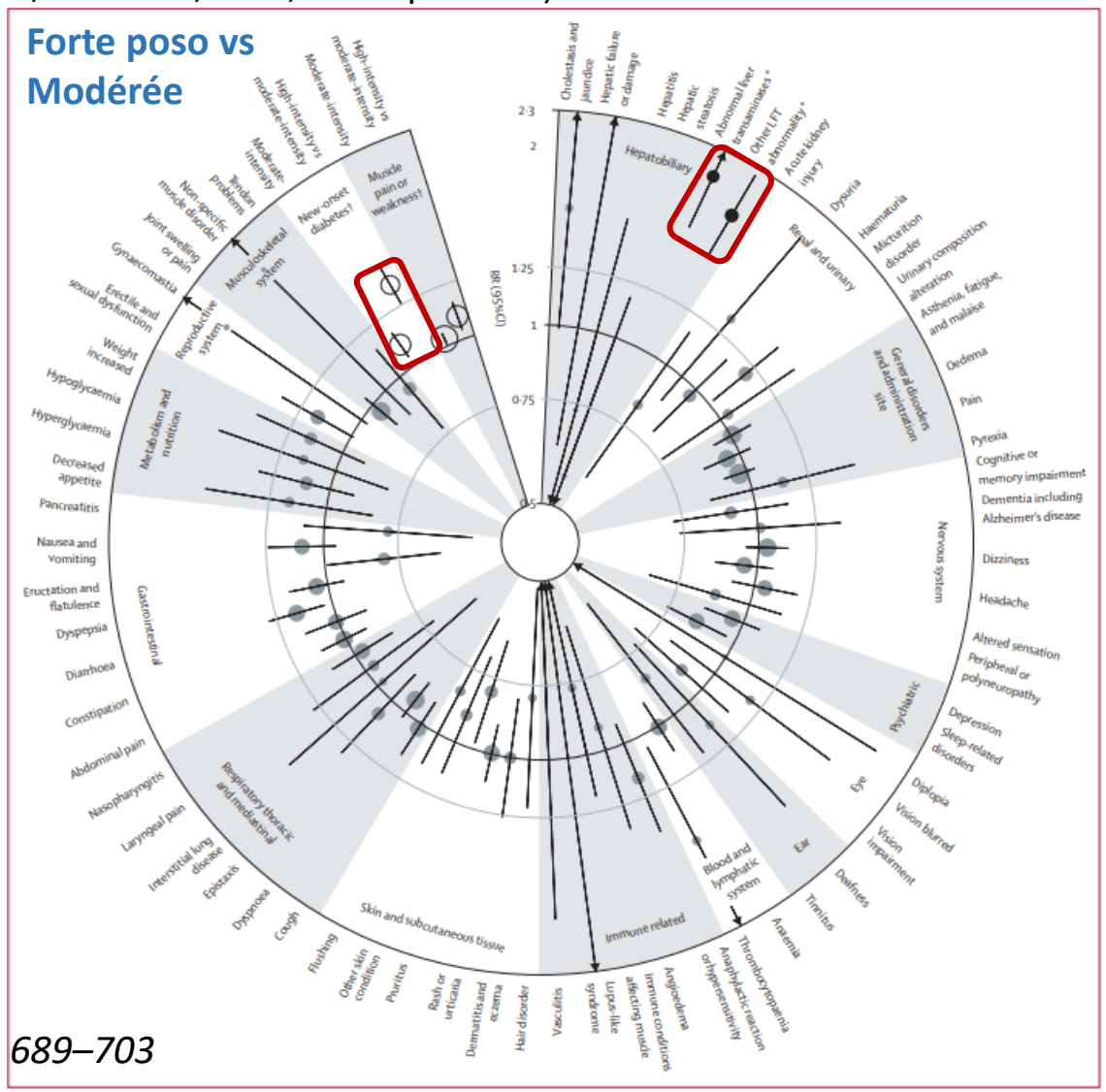
Effets des statines sur les effets indésirables listés dans les notices

- CTT Collaboration: 123 940 participants, median follow-up 4·5 years; 19 essais vs placebo et 4 forte poso vs modérée
- **Risque augmenté pour muscles/diabète/biologie hépatique/protéinurie**
- **Aucune différence significative pour 62 / 66 EI listés** (cognition, sommeil, sexe, neuropathie…)

Statine vs Placebo



Forte poso vs Modérée

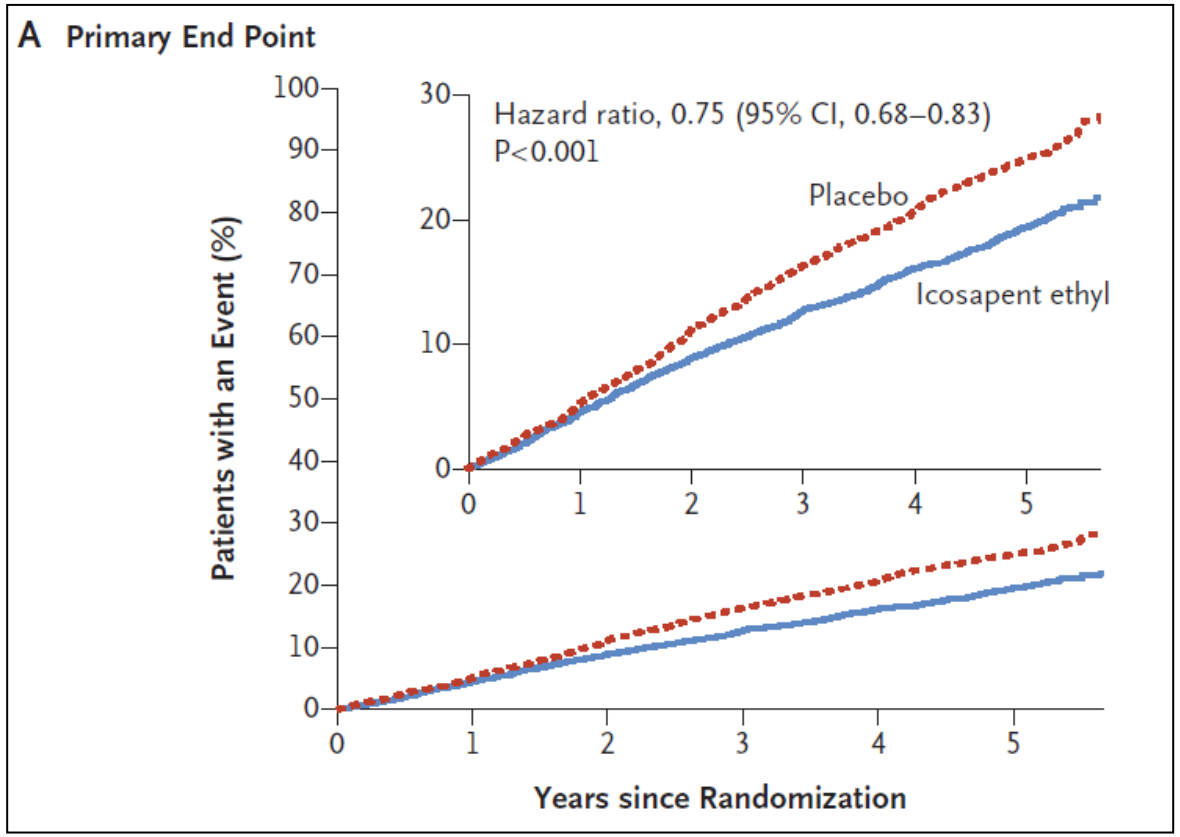


Lancet 2026; 407: 689–703

Nutrition

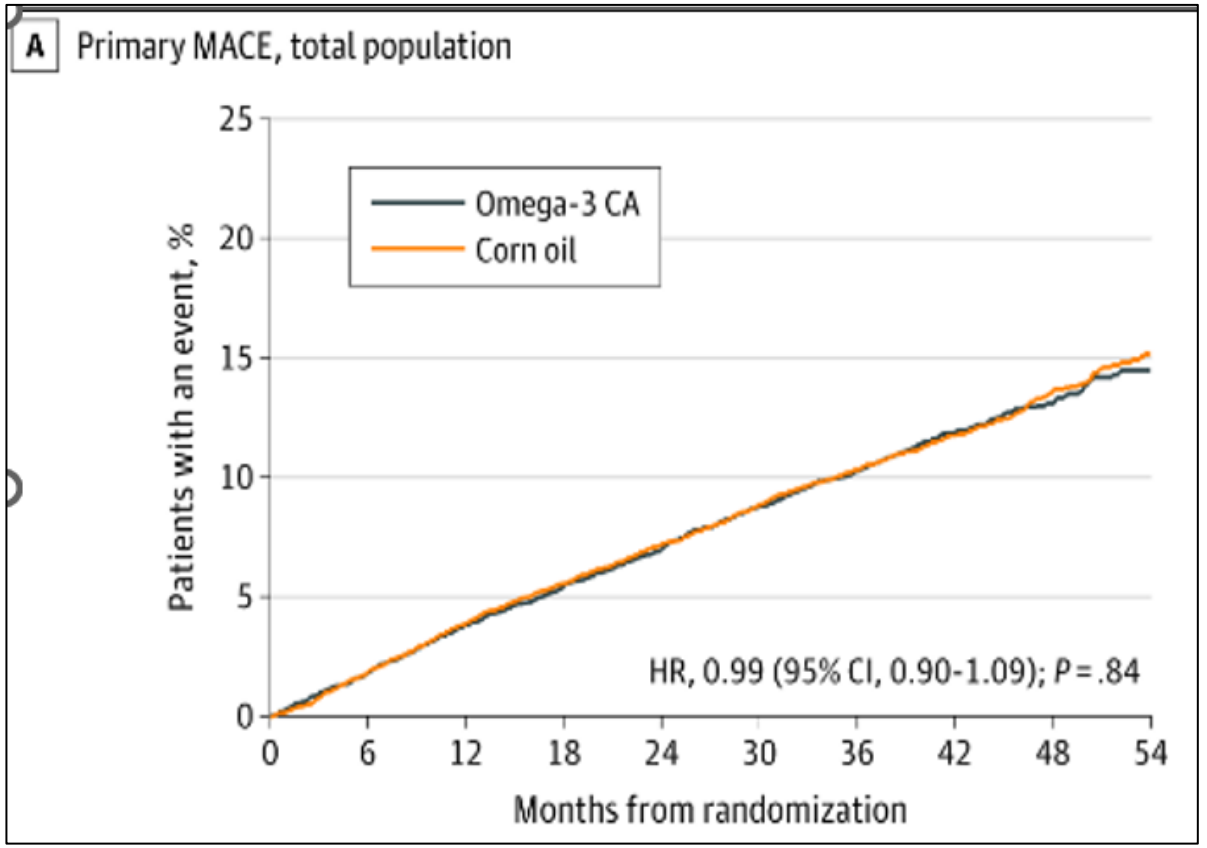
Des résultats très différents de supplémentation Om-3 forte dose entre EPA pur et EPA+DHA

REDUCE-IT
EPA 4 g/d vs placebo



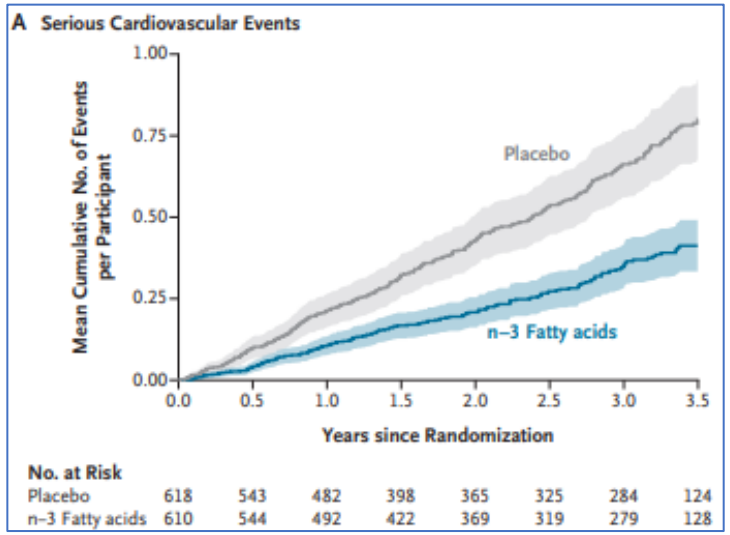
Bhatt DL, N Engl J Med 2019;380:11-22

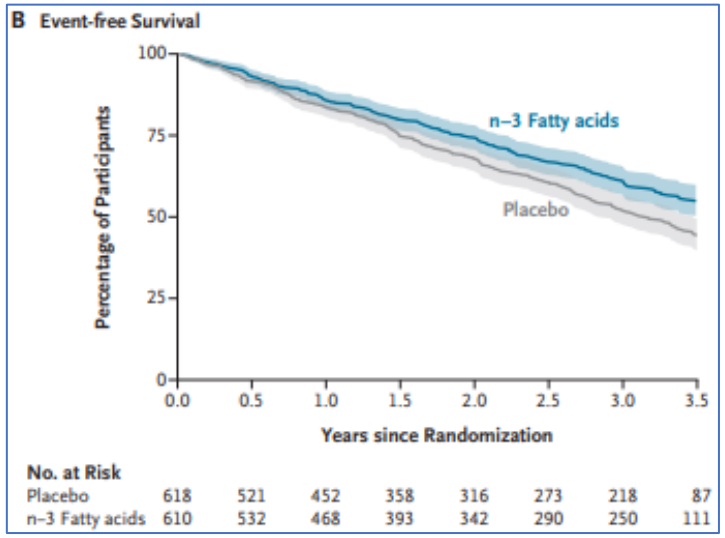
STRENTGTH
EPA + DHA 4 g/d vs placebo

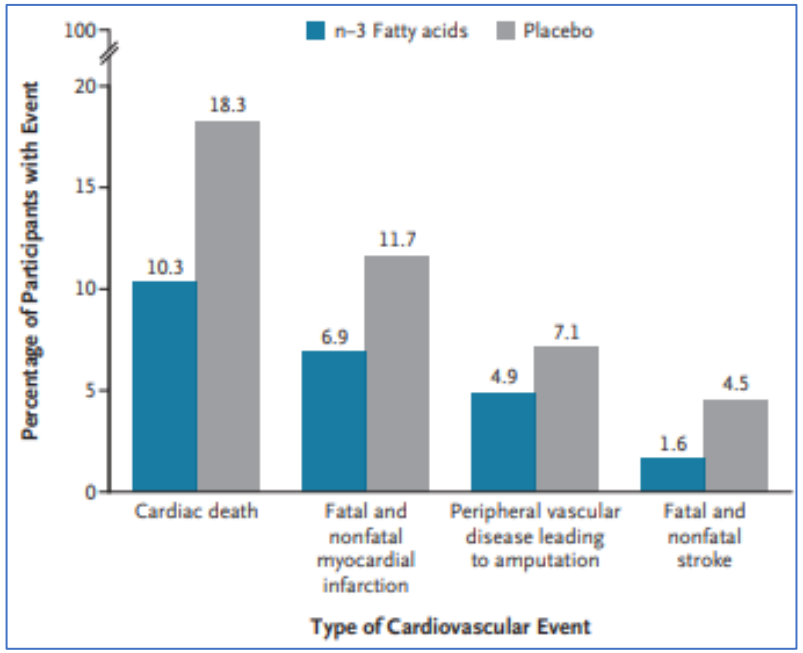


Nicholls, JAMA Nov 2020

Fish-Oil Supplementation (EPA+DHA) and Cardiovascular Events in Patients Receiving Hemodialysis: PISCES Study







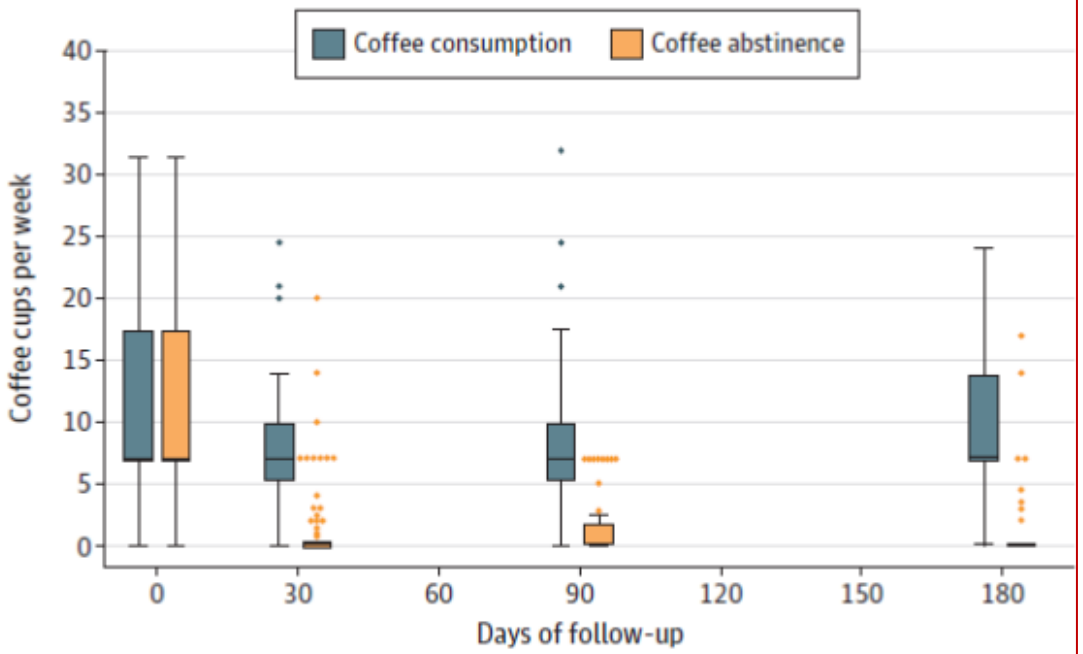
- RCT: 4 g of marine Om-3 FA [1.6 g of EPA and 0.8 g of DHA] vs corn-oil placebo
- 1228 participants with hemodialysis
- 3,5 yrs follow-up

Lok, NEJM 2025

Café et FA: *DECAF Randomized Clinical Trial*

- Essai prospectif randomisé x 6 mois
- 200 sujets avec FA adressés pour CEE
- Conso moy basale = 7 tasses café / sem.
- Rando: Café idem vs Abstinence café

Figure 2. Changes in Coffee Intake by Randomization Group

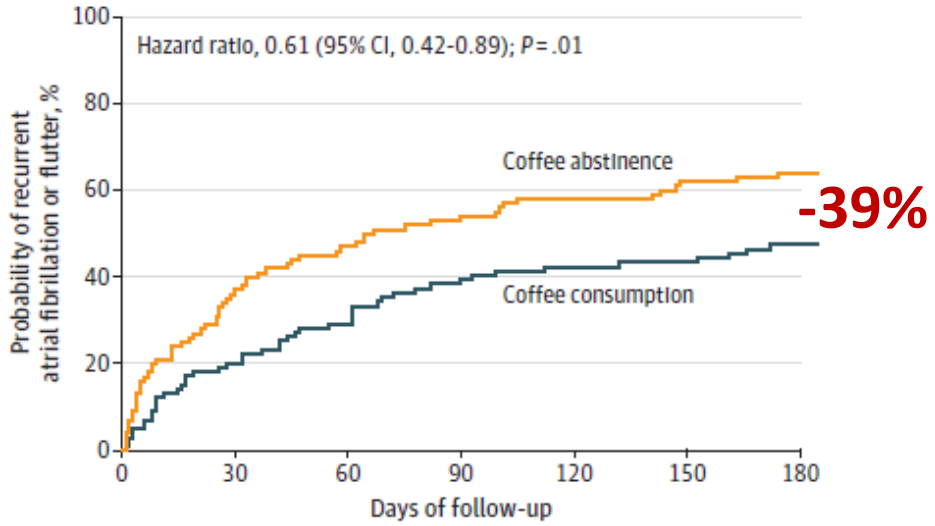


No. at risk							
Coffee consumption	100	79	70	61	57	56	52
Coffee abstinence	100	64	53	47	42	38	36

Wong, JAMA 2026;335;(4):317-325

The DECAF Randomized Clinical Trial

Figure 3. Time to Recurrence of Atrial Fibrillation or Flutter



No. at risk

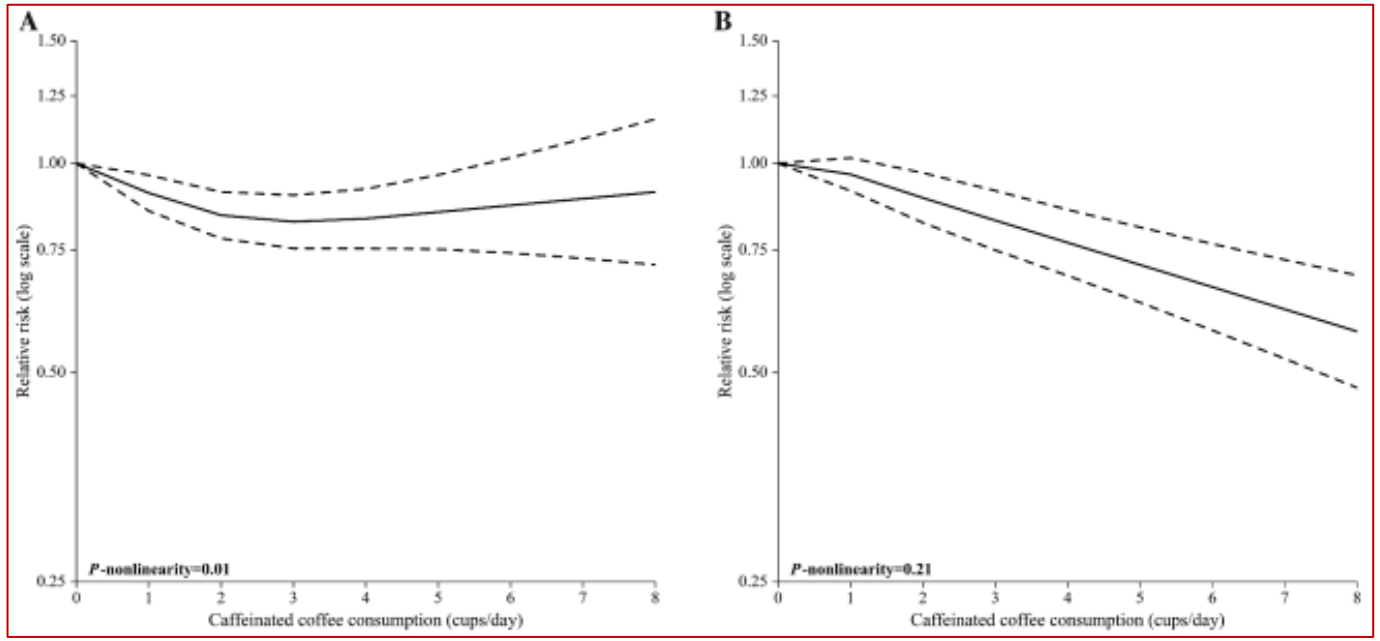
Coffee consumption	100	79	70	61	57	56	52
Coffee abstinence	100	64	53	47	42	38	36

Hypothèses mécanistiques:

- Diminution du tonus vagal
- Augmentation de la période réfractaire auriculaire (modèles animaux)
- Réduction modérée de la pression artérielle
- Adénosine bloquée par la caféine.
- Autres composés anti-inflammatoires du café

Wong, JAMA 2026;335;(4):317-325

Pooled dose–response association (meta-analysis) between caffeinated coffee consumption (cups per day) and cardiovascular disease incidence/mortality (A) and type 2 diabetes incidence (B). *United States, 1987–2017.*



Di Maso, Adv Nutr 2021

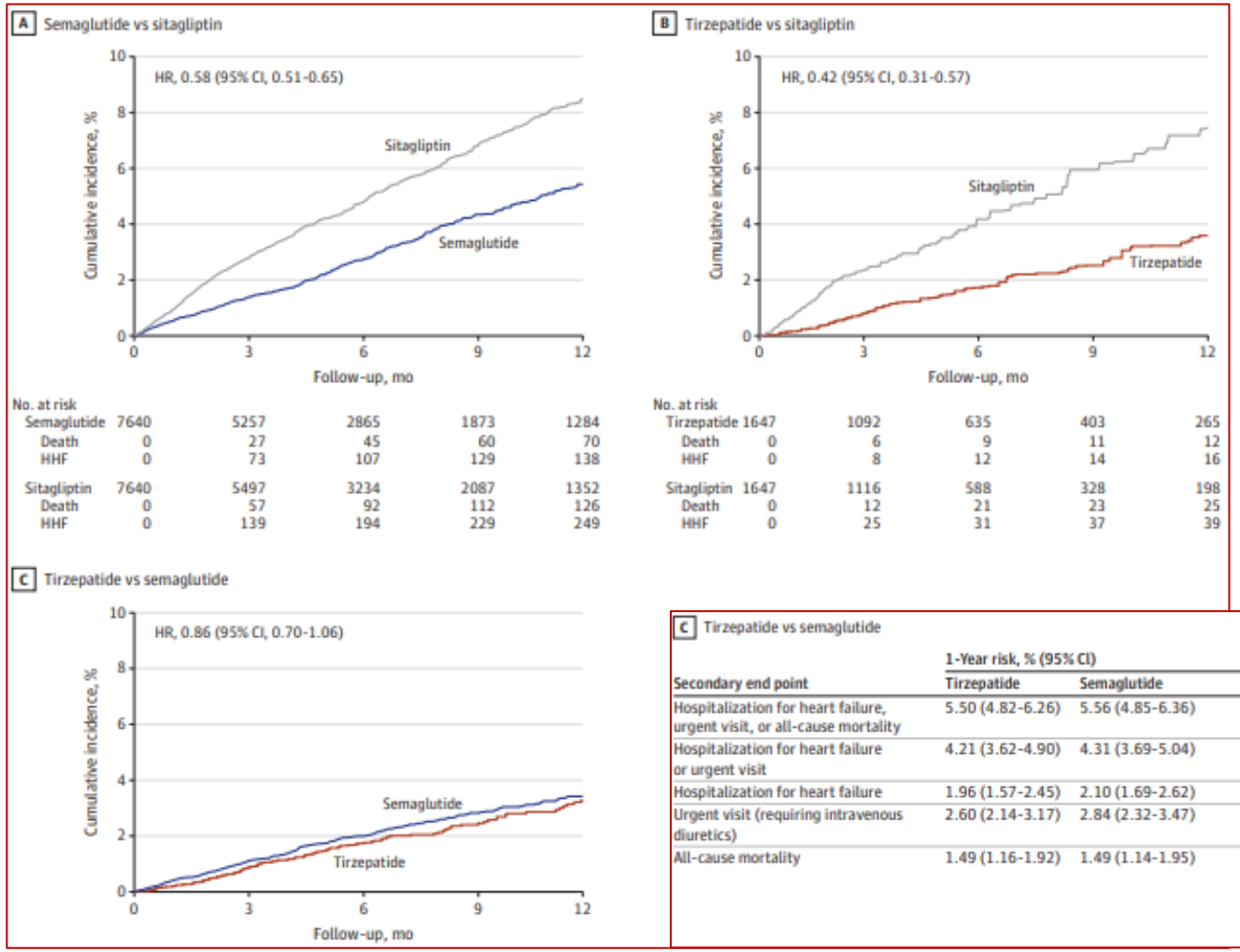
Outcome	Caffeinated coffee consumption, cups/d							
	1 RR (95% CI)	2 RR (95% CI)	3 RR (95% CI)	4 RR (95% CI)	5 RR (95% CI)	6 RR (95% CI)	7 RR (95% CI)	8 RR (95% CI)
CVD incidence/mortality (10 cohorts)	0.91 (0.85, 0.96)	0.84 (0.78, 0.91)	0.82 (0.75, 0.90)	0.83 (0.75, 0.92)	0.85 (0.75, 0.96)	0.87 (0.74, 1.02)	0.89 (0.73, 1.08)	0.91 (0.71, 1.16)
T2D incidence (11 cohorts)	0.96 (0.91, 1.02)	0.89 (0.82, 0.97)	0.83 (0.75, 0.91)	0.77 (0.69, 0.86)	0.71 (0.63, 0.81)	0.66 (0.58, 0.77)	0.62 (0.52, 0.73)	0.57 (0.48, 0.69)
HCC incidence (10 cohorts[2])	1.02 (0.72, 1.45)	0.82 (0.52, 1.29)	0.71 (0.52, 0.96)	0.61 (0.47, 0.80)	0.53 (0.35, 0.78)	0.45 (0.25, 0.81)	0.39 (0.18, 0.86)	0.34 (0.12, 0.93)
Endometrial cancer incidence (4 cohorts)	0.94 (0.84, 1.06)	0.91 (0.81, 1.02)	0.82 (0.73, 0.92)	0.74 (0.64, 0.85)	0.67 (0.55, 0.81)	0.60 (0.47, 0.77)	0.55 (0.40, 0.74)	0.49 (0.34, 0.71)
Melanoma incidence (4 cohorts)	0.91 (0.81, 1.03)	0.89 (0.77, 1.03)	0.86 (0.75, 0.98)	0.83 (0.72, 0.95)	0.79 (0.67, 0.94)	0.76 (0.62, 0.95)	0.73 (0.56, 0.96)	0.71 (0.51, 0.98)
Nonmelanoma skin cancer incidence (3 cohorts)	0.96 (0.93, 0.98)	0.92 (0.89, 0.94)	0.88 (0.86, 0.91)	0.85 (0.82, 0.88)	0.82 (0.78, 0.86)	0.78 (0.73, 0.84)	0.75 (0.69, 0.83)	0.73 (0.65, 0.82)

Estimation du bénéfice cardiovasculaire associée à la réduction de la quantité de sel dans le pain en France

- Consommation moyenne de sel en France = 8,2 g/j
- **PNNS**: objectif de réduction de sel dans le pain -30%
  - 2015-2025: objectif (réalisé) de **réduction du sel de 1,7 g à 1,1-1,4 g/100g**
- Effet estimé sur PA: - 0.21/0.14 mmHg
- Impact potentiel estimé:
  - **- 0.78% d'événements CV: 8400 hospitalisations/an**
  - - 1.04% SCA; - 1.05% AVC hémorragique; - 0.88 % AVC isch; - 0.58% Ins Card
  - **Mortalité globale – 0.18% (N=1186)**
- Impact plus marqué chez:
  - Les hommes
  - Les hommes et femmes de 55-64 ans

Grave C, Hypertension janvier 2026

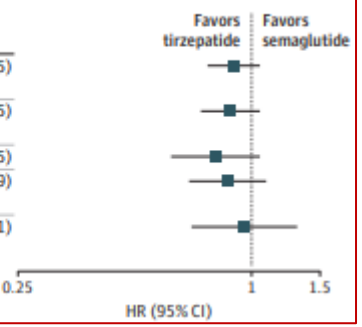
Chez le sujet diabétique obèse, le sémaglutide et le tirzépatide, par comparaison à la sitagliptine, réduisent chacun le risque de décès et d'hospitalisation pour insuffisance cardiaque, sans différence significative entre sémaglutide et tirzépatide.



- 5 études de cohortes USA (Semag-Tirzep et Sitagliptine)
- Application des résultats des 2 études RCT: STEP-HFpEF DM (semaglutide) and SUMMIT (tirzepatide)

C Tirzepatide vs semaglutide

Secondary end point	1-Year risk, % (95% CI) Tirzepatide	Semaglutide	Risk difference	HR (95% CI)
Hospitalization for heart failure, urgent visit, or all-cause mortality	5.50 (4.82-6.26)	5.56 (4.85-6.36)	-0.06 (-1.04 to -0.94)	0.90 (0.77-1.05)
Hospitalization for heart failure or urgent visit	4.21 (3.62-4.90)	4.31 (3.69-5.04)	-0.10 (-0.97 to 0.14)	0.88 (0.74-1.05)
Hospitalization for heart failure	1.96 (1.57-2.45)	2.10 (1.69-2.62)	-0.14 (-0.79 to 0.48)	0.81 (0.62-1.05)
Urgent visit (requiring intravenous diuretics)	2.60 (2.14-3.17)	2.84 (2.32-3.47)	-0.24 (-0.99 to 0.49)	0.87 (0.69-1.09)
All-cause mortality	1.49 (1.16-1.92)	1.49 (1.14-1.95)	0.00 (-0.51 to 0.54)	0.96 (0.70-1.31)



Kruger N, JAMA
doi:10.1001/jama.2025.14092

Merci de votre attention…

Bon congrès !