

La vérité peut elle venir des registres ?



C'est quoi la vérité à l'ère des fake news ?



QAnon, la pandémie venue des États-Unis

16% de platistes aux EU



La science n'y échappe pas?



« la croyance est plus forte que la raison »
Etienne Klein : la déchéance de rationalité

Même les journaux de référence !

The Lancet

Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis

Mandeep R Mehra, Sapan S Desai, Frank Ruschitzka, Amit N Patel

Summary

Background Hydroxychloroquine or chloroquine, often in combination with a second-generation macrolide, are being widely used for treatment of COVID-19, despite no conclusive evidence of their benefit. Although generally safe when used for approved indications such as autoimmune disease or malaria, the safety and benefit of these treatment regimens are poorly evaluated in COVID-19.

Methods We did a multinational registry analysis of the use of hydroxychloroquine, chloroquine with or without a macrolide for treatment of COVID-19. The registry comprised data from 671 hospitals in 44 countries. We included patients hospitalised between Dec 20, 2019, and April 14, 2020, with a positive laboratory test for SARS-CoV-2. Patients who received one of the treatments of interest within 48 h of diagnosis were included in one of four treatment groups (chloroquine alone, chloroquine with a macrolide, hydroxychloroquine alone, or hydroxychloroquine with a macrolide), and patients who received none of these treatments formed the control group. Patients for whom one of the treatments of interest was initiated more than 48 h after diagnosis or while they were on mechanical ventilation, as well as patients who received remdesivir, were excluded. The main outcome of interest was in-hospital mortality and the occurrence of de-novo ventricular arrhythmias (as defined on the basis of ventricular tachycardia or ventricular fibrillation).

Findings 96 032 patients (mean age 53·8 years, 46·3% women) with COVID-19 were hospitalised during the study period and met the inclusion criteria. Of these, 18 668 patients were in the treatment groups (1868 received chloroquine, 3783 received chloroquine with a macrolide, 3016 received hydroxychloroquine, and 6221 received hydroxychloroquine with a macrolide) and 77 364 patients were in the control group. 10 698 (11·1%) patients died in hospital. After controlling for multiple confounding factors (age, sex, race or ethnicity, body-mass index, underlying cardiovascular disease and its risk factors, diabetes, underlying lung disease, smoking, immunosuppressed condition, and baseline disease severity), when compared with mortality in the control group (9·3%), hydroxychloroquine (18·0%; hazard ratio 1·335, 95% CI 1·225–1·457), hydroxychloroquine with a macrolide (23·8%; 1·447, 1·368–1·531), chloroquine (16·4%; 1·365, 1·238–1·531), and chloroquine with a macrolide (22·2%; 1·368, 1·273–1·469) were each independently associated with an increased risk of in-hospital mortality. Compared with the control group (0·3%), hydroxychloroquine (6·0%; 2·365, 1·935–2·906), hydroxychloroquine with a macrolide (8·1%; 5·106, 4·106–5·983), chloroquine (4·3%; 1·711, 1·290–4·596), and chloroquine with a macrolide (6·5%; 4·011, 3·344–4·812) were independently associated with an increased risk of de-novo ventricular arrhythmia during hospitalisation.

Interpretation We were unable to confirm a benefit of hydroxychloroquine or chloroquine, when used alone or with a macrolide, on in-hospital outcomes for COVID-19. Each of these drug regimens was associated with decreased in-hospital mortality, but also with increased frequency of ventricular arrhythmias when used for treatment of COVID-19.

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NEJM

ORIGINAL ARTICLE

Cardiovascular Disease, Drug Therapy, and Mortality in Covid-19

Mandeep R. Mehra, M.D., Sapan S. Desai, M.D., Ph.D., SreyRam Kuy, M.D., M.H.S., Timothy D. Henry, M.D., and Amit N. Patel, M.D.

ABSTRACT

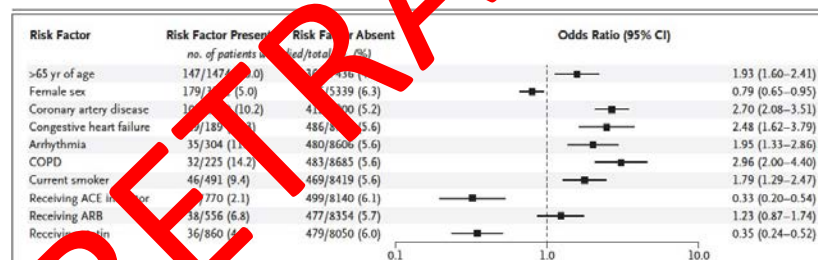


Fig 1. Independent Predictors of In-Hospital Death from Multivariable Logistic-Regression Analysis. Number and percentage of patients with each risk factor who died (risk factor present) and of patients without each risk factor who died (risk factor absent) are shown. The 95% confidence intervals (CIs) of the odds ratios have not been adjusted for multiple testing and should not be used to infer definitive effects. ACE denotes angiotensin-converting enzyme, ARB angiotensin-receptor blocker, and COPD chronic obstructive pulmonary disease.

Conditions pour qu'un registre dise la vérité

- ✓ Qualité des données
- ✓ Porté par les professionnels
- ✓ Financement institutionnel



France – PCI

Projet du GACI



Qualité des données Exhaustivité

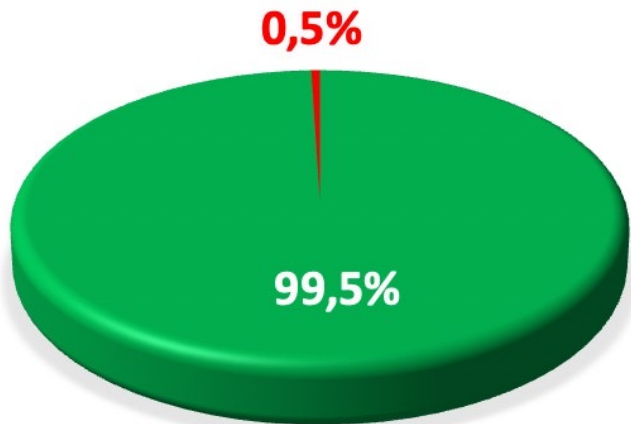
Pas de double capture
au sein du logiciel métier

Saisie obligatoire des données

TEC sur place

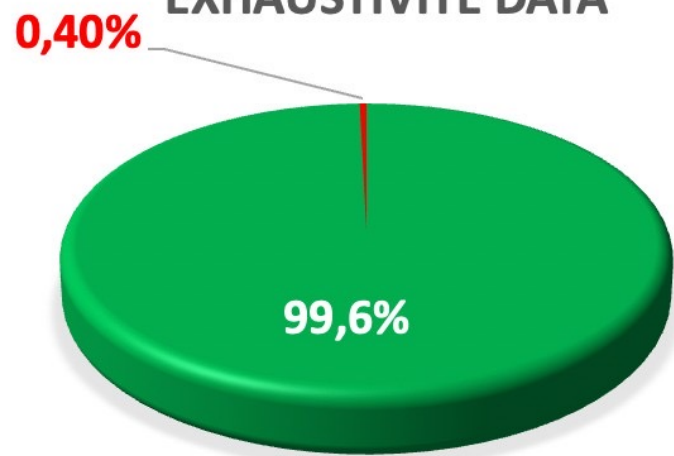


EXHAUSTIVITÉ EXAMENS



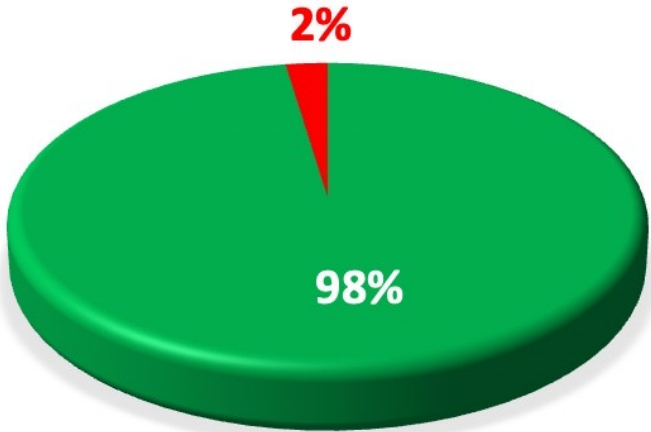
■ refus patient

EXHAUSTIVITÉ DATA



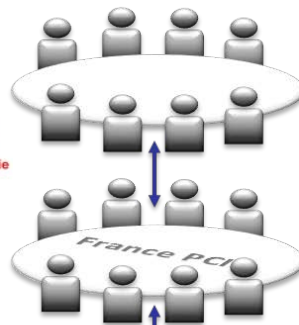
■ datas non obligatoires

SUIVI 1 AN



■ perdu de vue

GACI / CNP



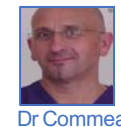
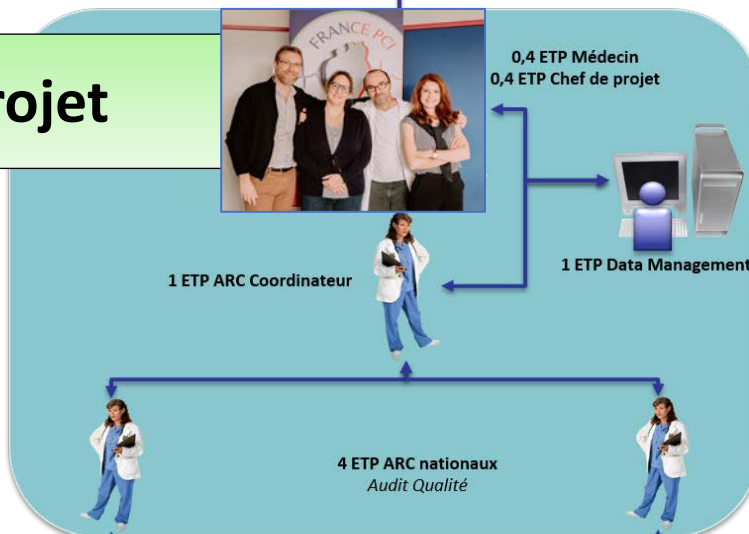
Comité de Pilotage

Financement

Equipe Projet

DGOS

URC cardiologie
Les Hôpitaux de Chartres

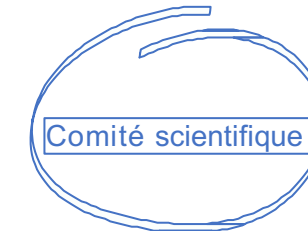
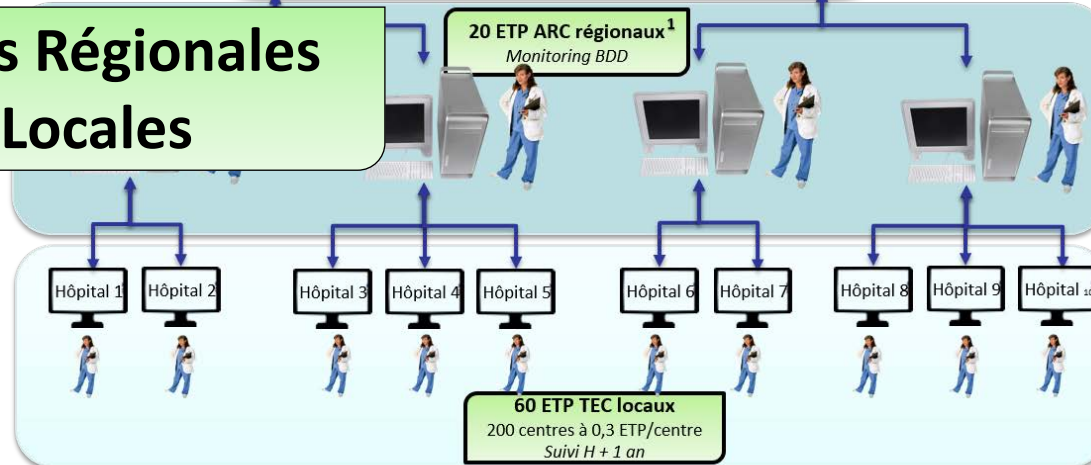


GACI

Equipes Régionales & Locales

ARS

DRCI
ou Assoc régionale



Pr JP Collet

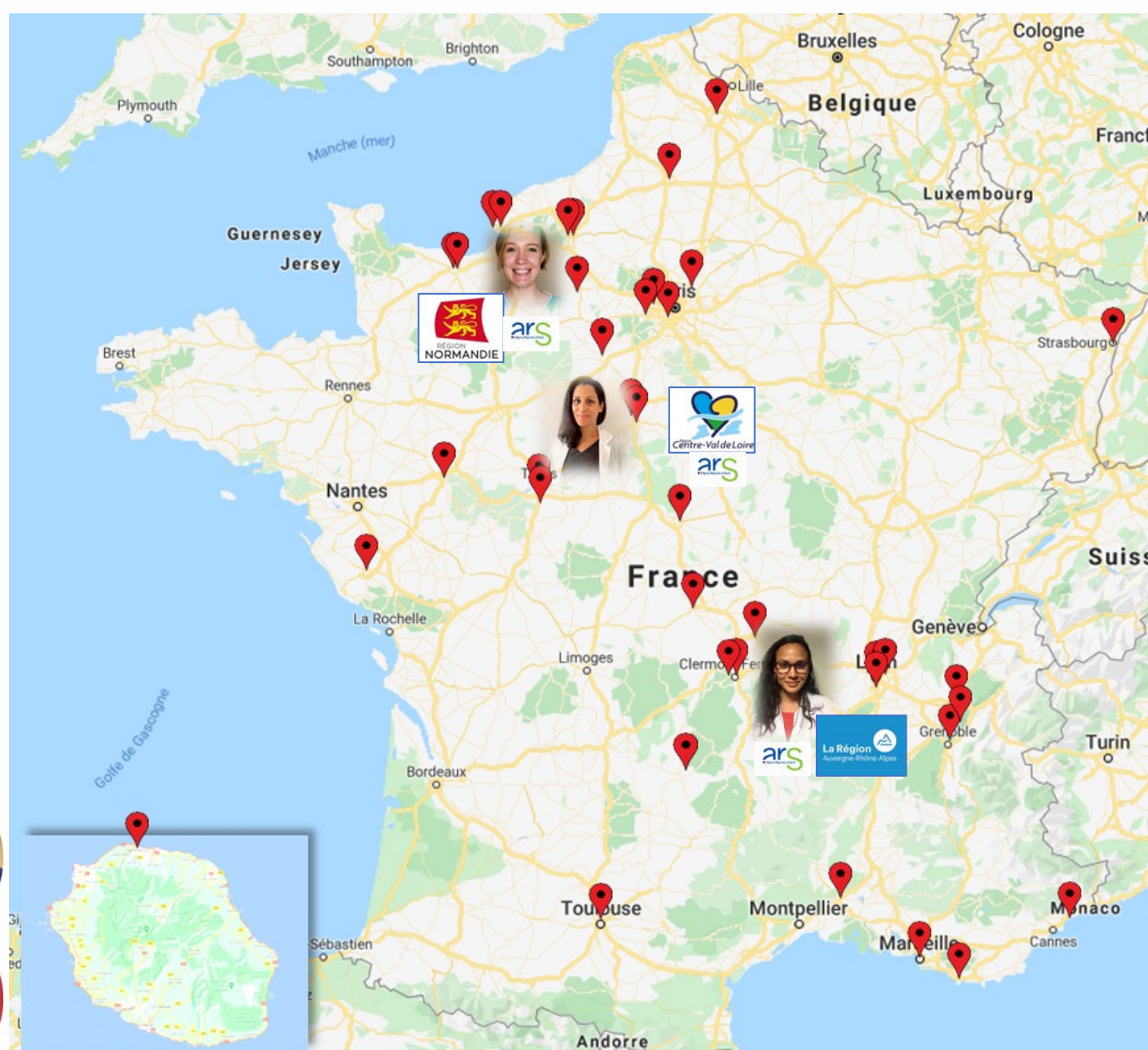
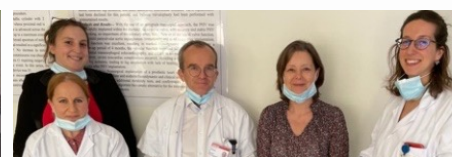
1 : 1 ETP ARC régional pour 3,5 millions d'habitants

ETP: Equivalent temps plein



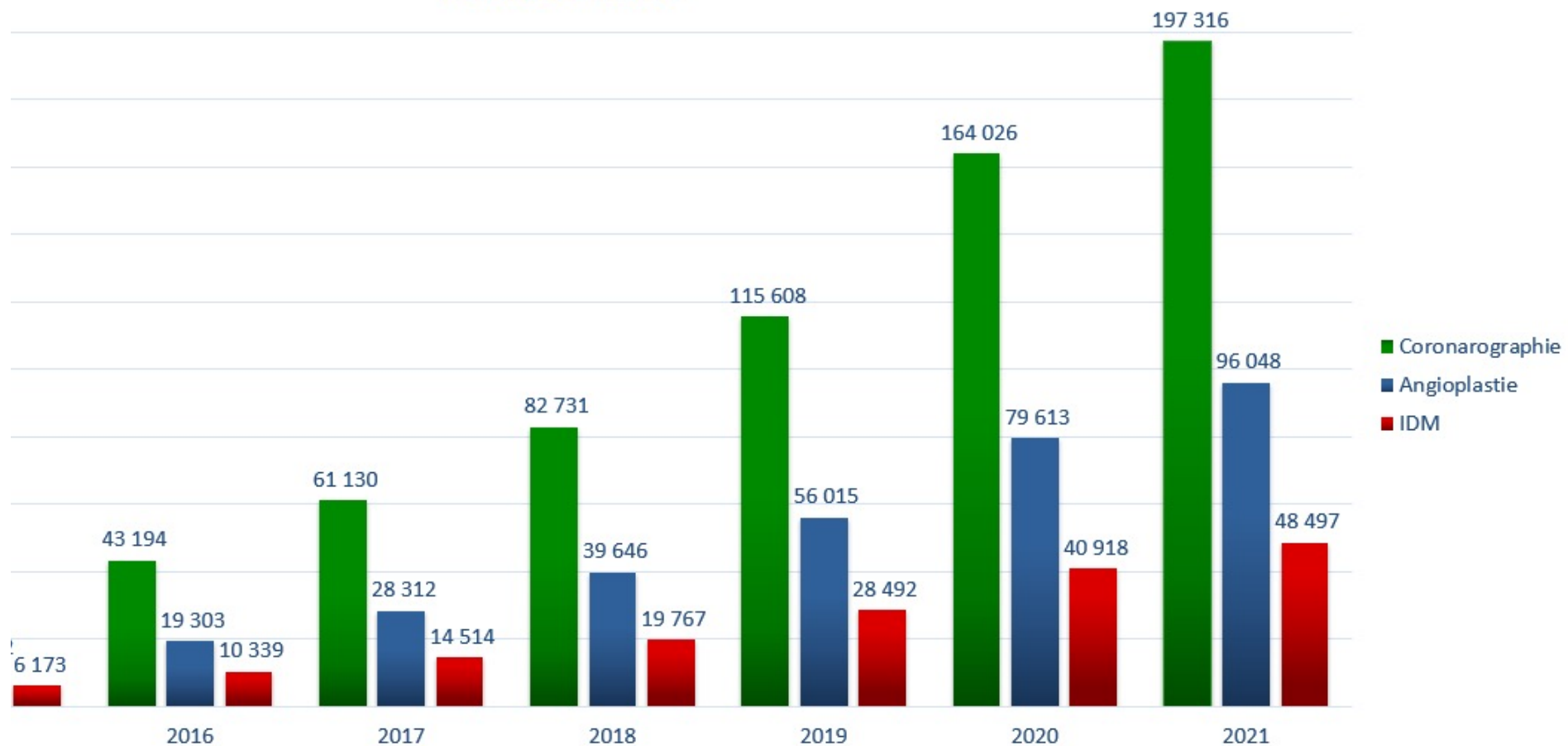
47 centres participants

- Centre Hospitalier de Chartres
- Centre Hospitalier de Bourges
- Clinique Saint Gatien (NCT+)
- CHR d'Orléans
- Clinique d'Orléance, Orléans
- CHRU de Tours
- Clinique Saint Hilaire, Rouen
- GH du Havre
- CHU de Caen
- CHU de Rouen
- Clinique Bergouignan, Evreux
- Hôpital Privé de l'Estuaire, Le Havre
- Clinique Saint Martin, Caen
- CHD Vendée, La Roche Sur Yon
- CHU Clermont Ferrand
- CH d'Aurillac
- GHM Grenoble
- CHU de Grenoble
- GVM La Rosaie, Aubervilliers
- Institut Mutualiste Montsouris, Paris
- CH Montluçon
- Pôle Santé République, Clermont Ferrand
- CH de Chambéry
- Clinique Cardiologie Urgences Amiens
- CH de Vichy
- Polyclinique Les Fleurs, Ollioules
- Institut Arnault Tzanck, St Laurent du Var
- Clinique Saint Joseph, Trélazé
- Hôpital Foch, Suresnes
- Clinique Pasteur, Toulouse
- Hôpital La Timone, Marseille
- CHU de Nîmes
- Médipôle, Lyon
- Hôpital Privé de Bois Bernard
- Clinique Sainte Clotilde, La Réunion
- Centre Hospitalier de Versailles
- CH Saint Joseph Saint Luc
- Clinique Rhéna, Strasbourg
- Clinique de la Sauvegarde, Lyon
- Clinique Convert, Bourg en Bresse
- CH de Cherbourg
- Hôpital Nord, Marseille
- Clinique Rive Gauche, Toulouse
- CHU de Lille
- CHU de Toulouse
- Clinique des Cèdres, Cornebarrieu
- Clinique Belledonne, Grenoble



Etat actuel

Activité Cumulée

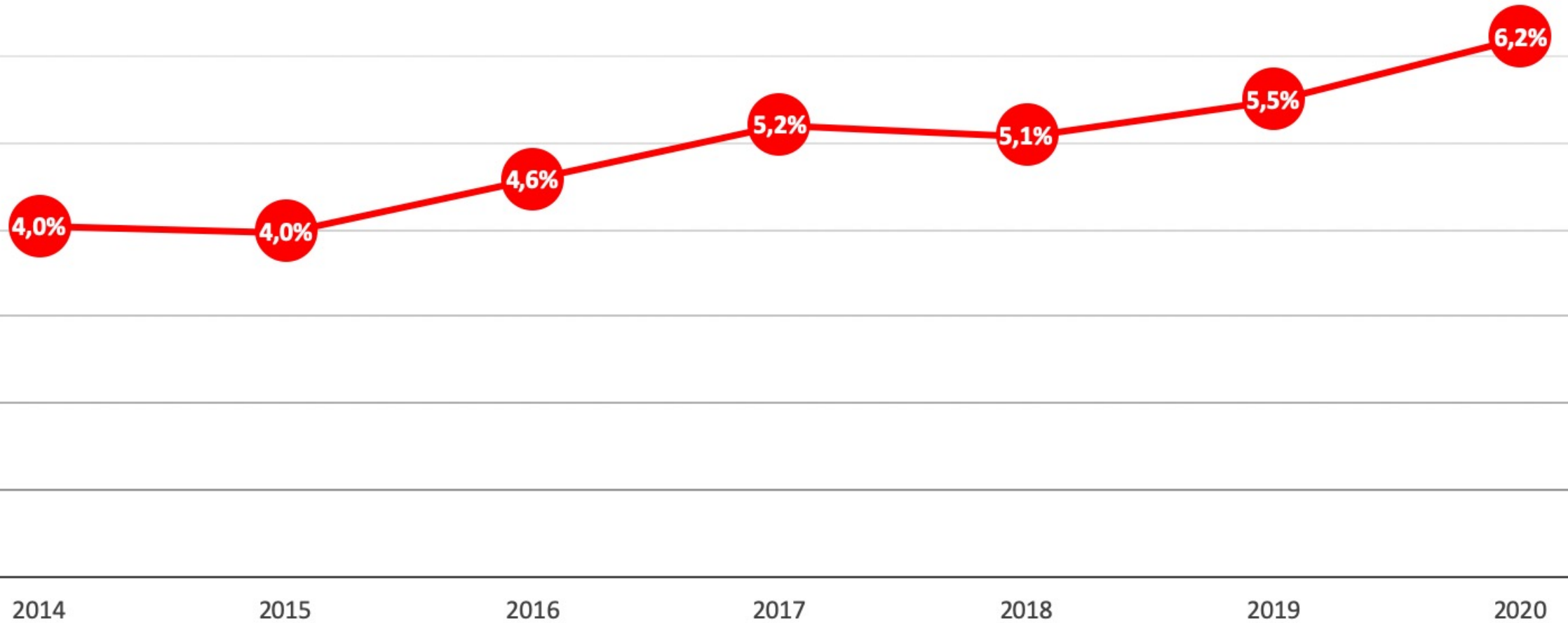
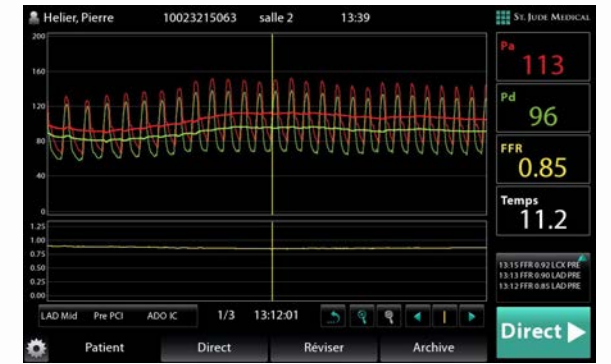




Quelles vérités peuvent donner
les registres?

Evolution des pratiques

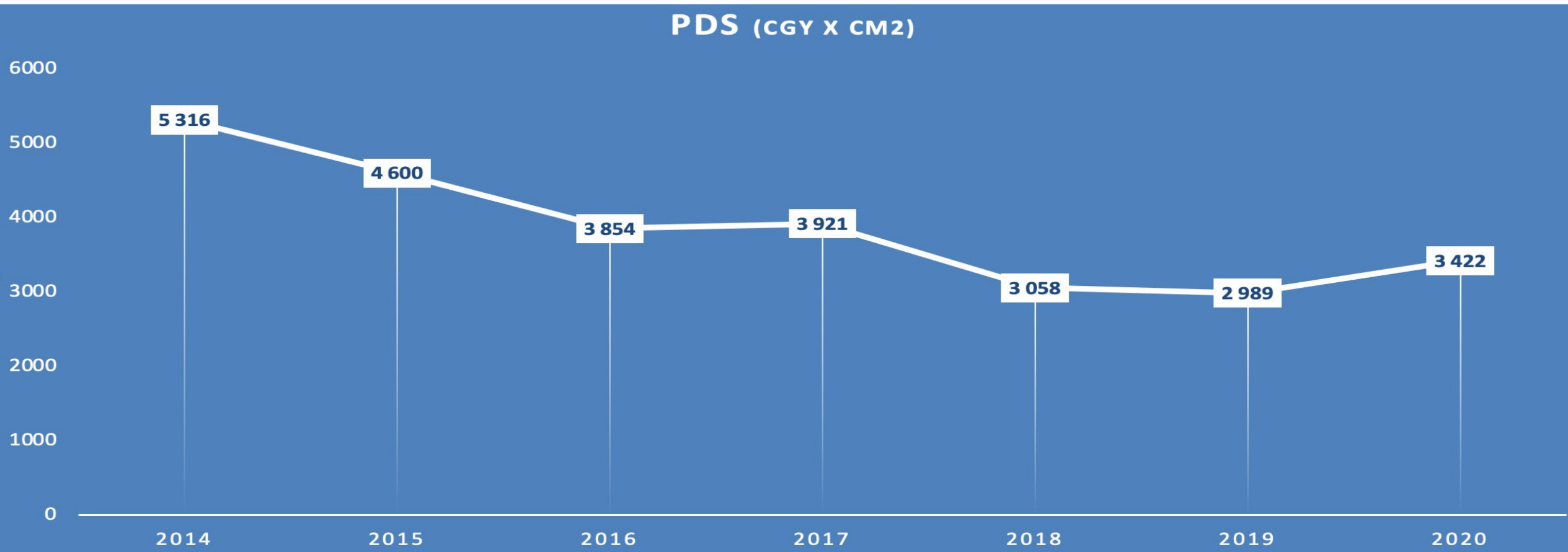
FFR/ATL



RADIO-PROTECTION / TOUTES ATL



PDS (CGY X CM2)

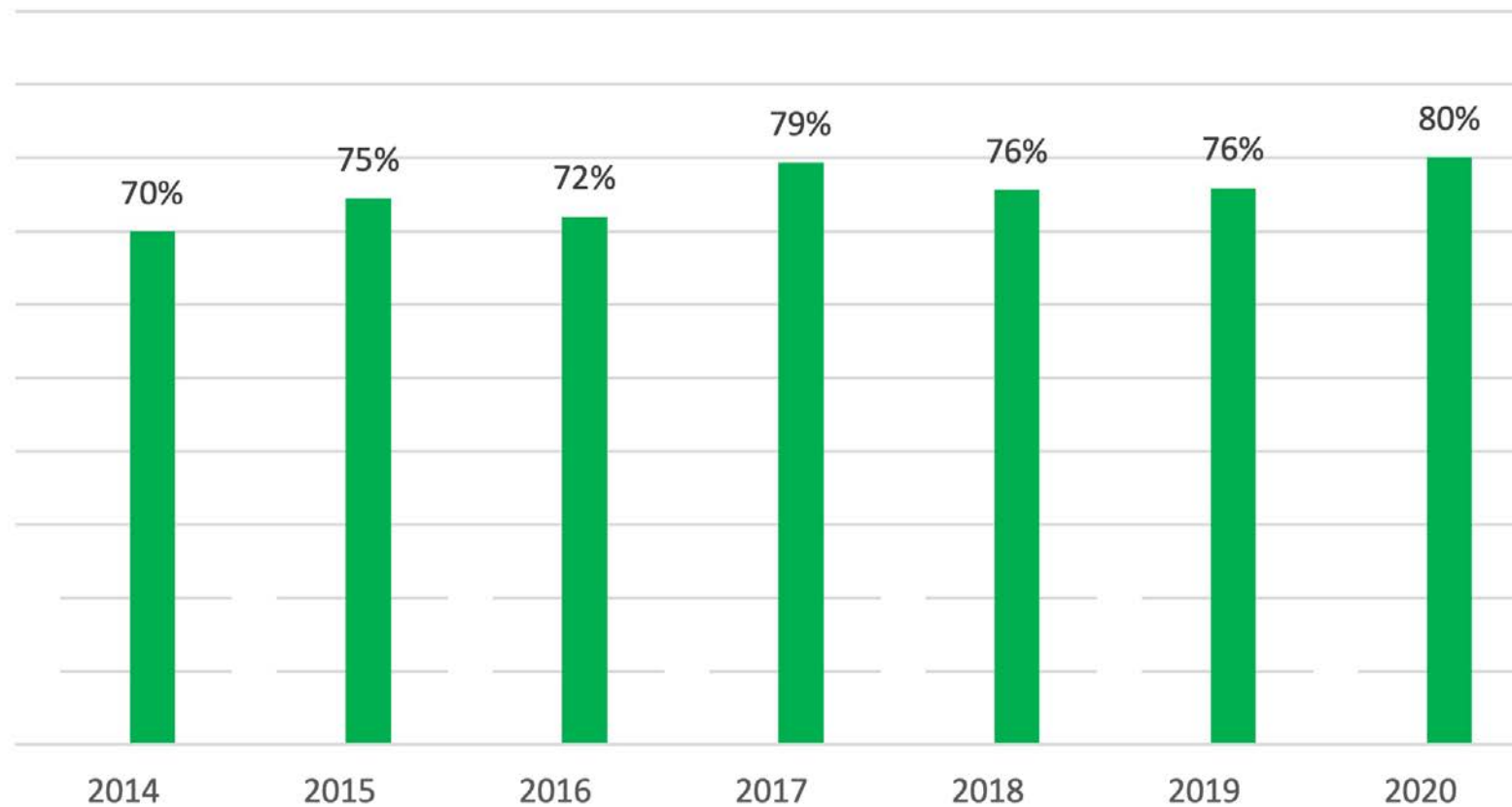


OCCLUSIONS CHRONIQUES (CTO)

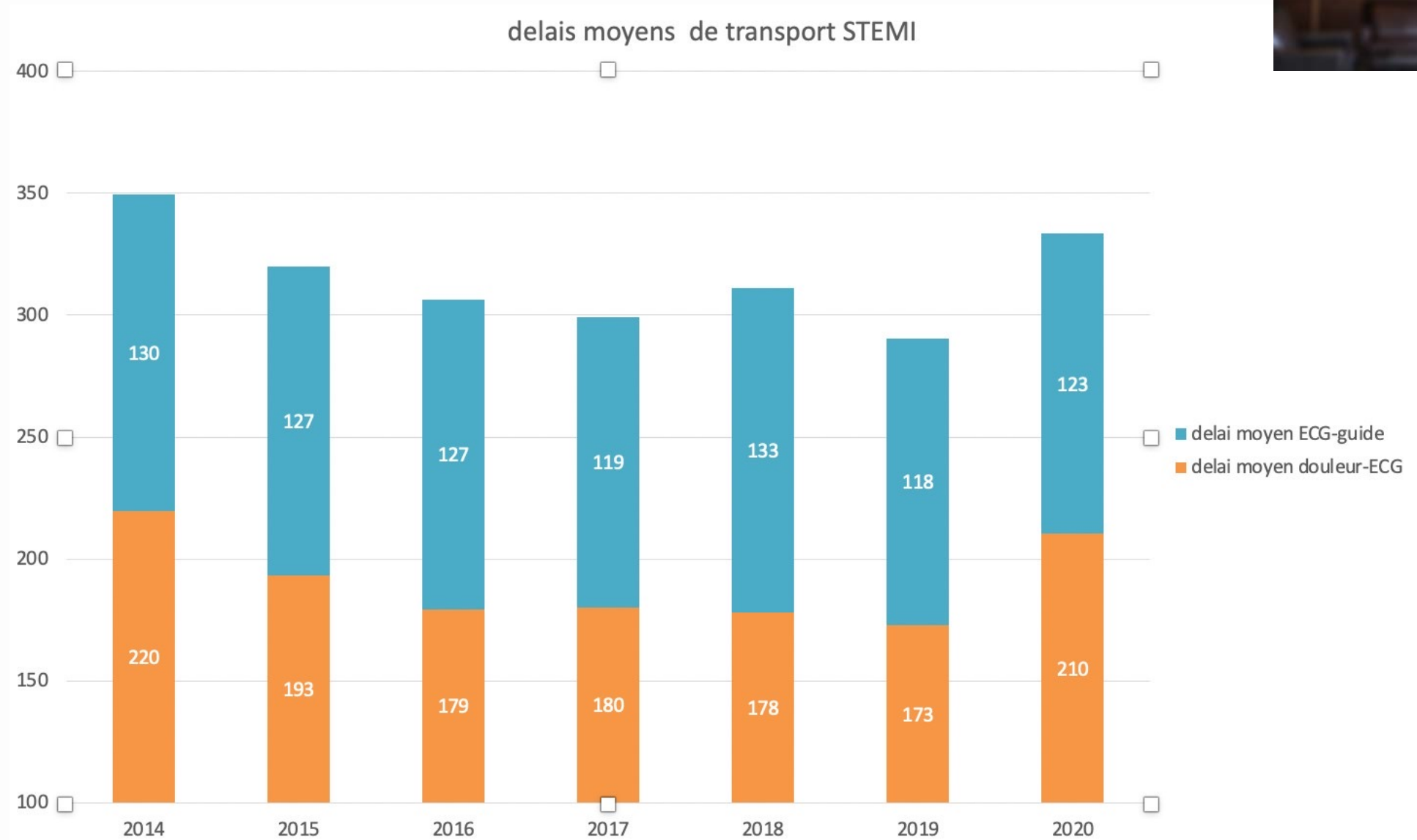
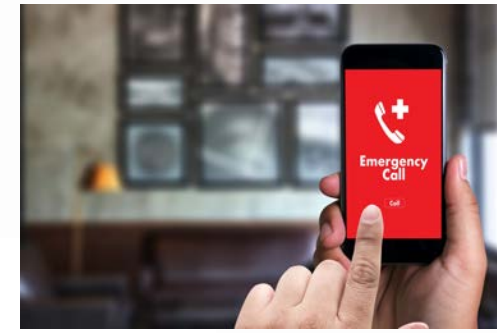


| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|-------------|------|------|------|------|------|------|------|
| % CTO / ATL | 3% | 4% | 4% | 4% | 4% | 3% | 3% |

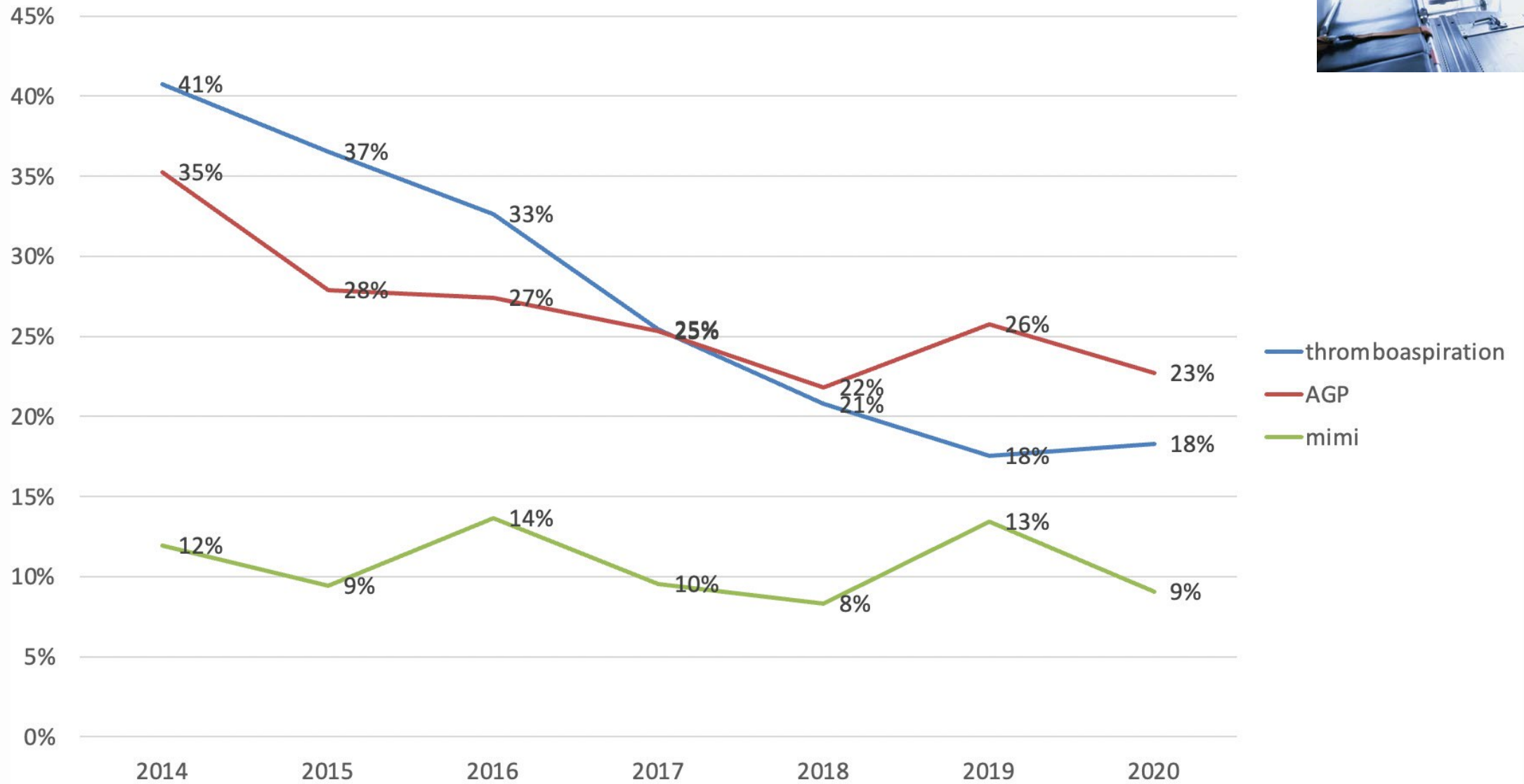
Taux de succès des CTO



DELAIS PRE HOSPITALIERS / SCA ST+ < H24



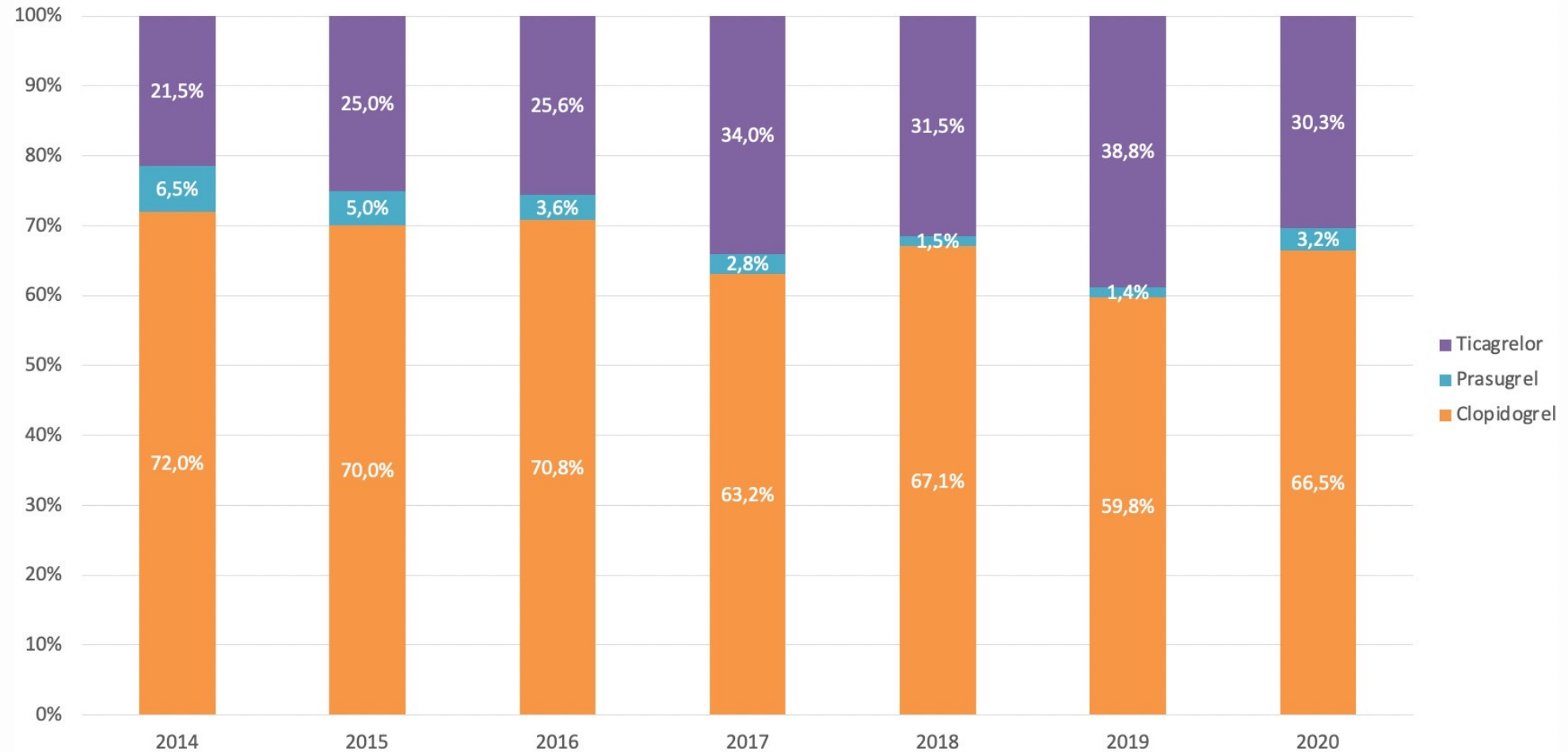
TRAITEMENTS ASSOCIÉS / STEMI < H24



TRAITEMENT SORTIE / ANGOR STABLE



Traitement de sortie P2Y12 SCC

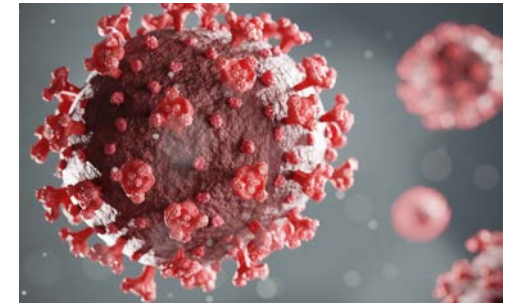
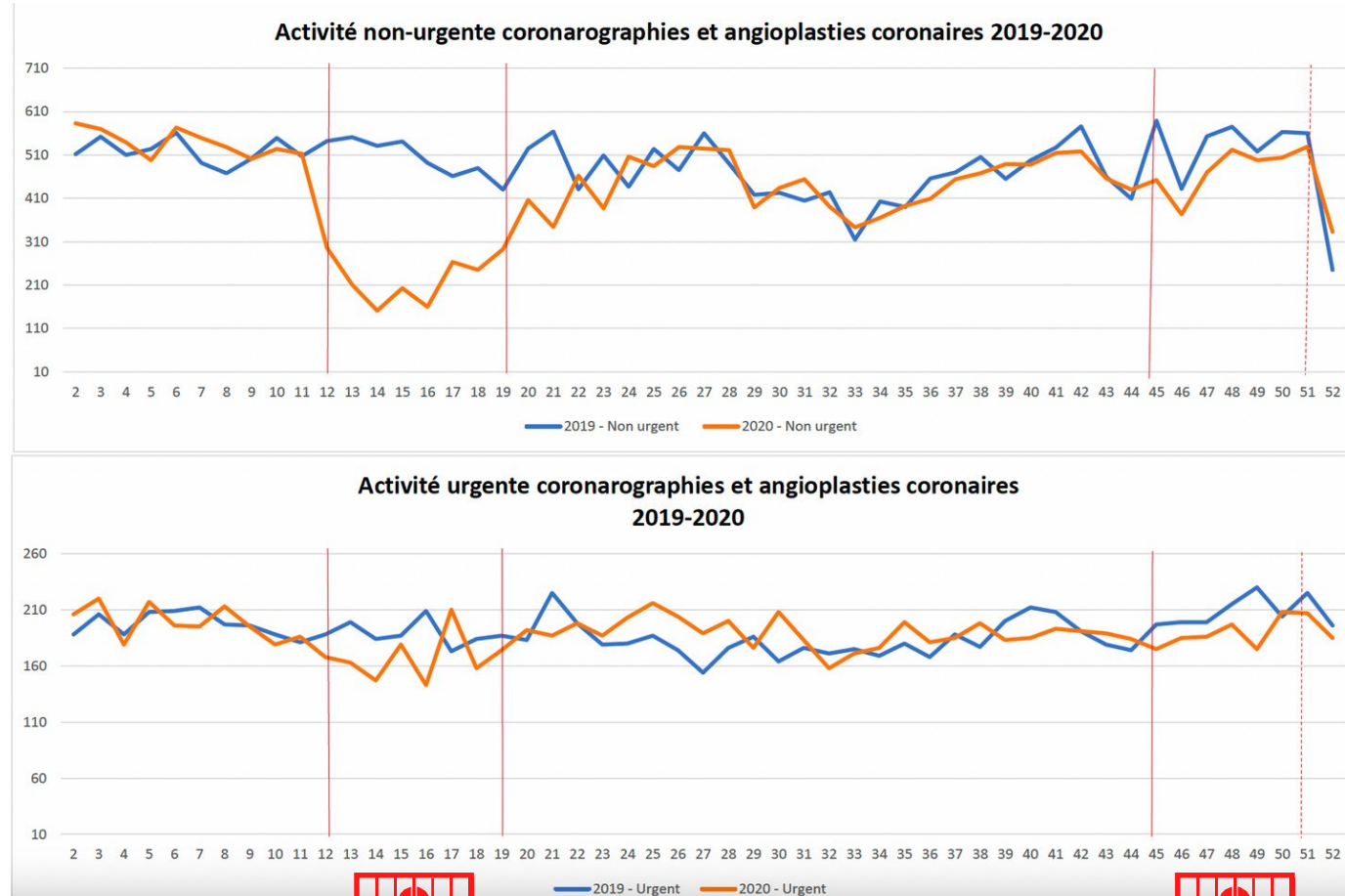


Alertes sanitaires

ACTIVITÉ MENSUELLE* : 2019 VS 2020

IMPACT DE LA PANDEMIE COVID-19

Durant le premier confinement, on a observé une baisse importante des activités programmées (-300 %) et même urgentes (-25 %) de cardiologie interventionnelle. Cette baisse d'activité n'a pas été noté durant le second confinement.



1er confinement



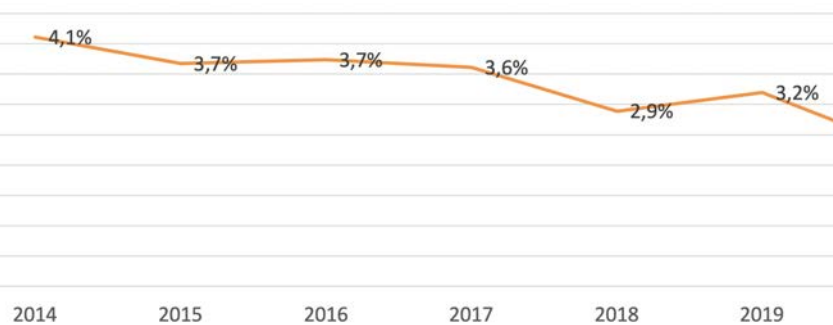
2d confinement

(*)Analyse faite sur les centres ouverts avant 01-01-2019

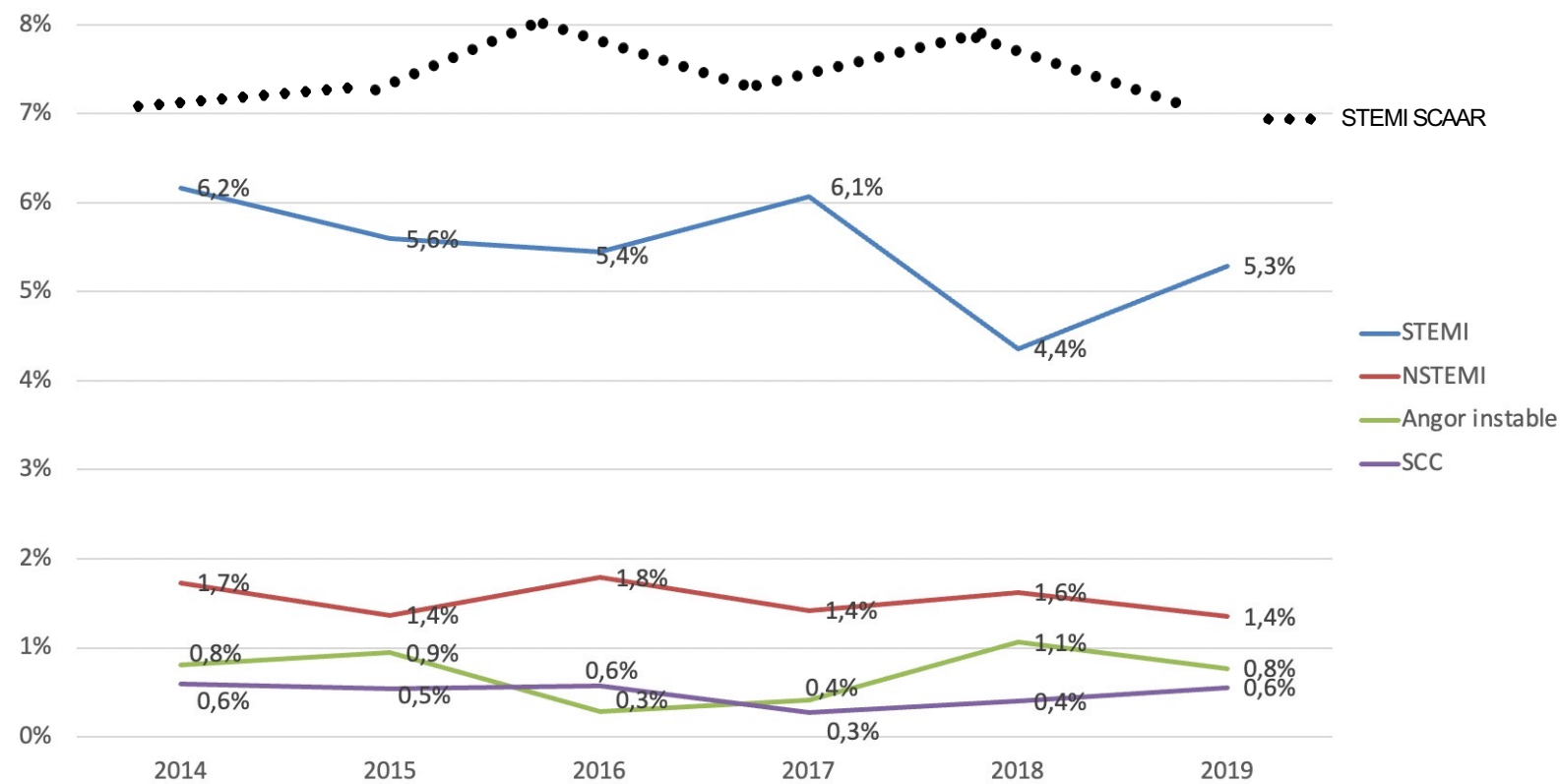
Evaluer nos pratiques

Mortalité à 1 mois / IDM (HAS / OCDE)

Mortalité à 30 jours STEMI et NSTEMI



Evolution du taux de mortalité à 30 j



Améliorer

INDICATEURS DE QUALITÉ

Indicateurs de pertinence

- Ratio ATL/coro
- Taux de coro <50 %
- ATL sans ischémie documentée

Indicateur de performance

- Taux de voie radiale
- Taux d'ATL en ambulatoire
- Taux de FFR et d'imagerie endo-coronaire (IVUS ou OCT)
- Taux de transfert direct en hôpital avec coro si appel 15

Indicateurs de sécurité

- PDS moyen et temps de scopie /ATL (radio-protection)
- Quantité moyenne de contraste /ATL (néphro-protection)

Indicateurs de bonnes pratiques

- Taux de nouveaux P2Y12 à la sortie H après ATL
- Taux de rééducation CV post STEMI

Indicateurs d'exhaustivité

- Taux de perdus de vue

Quality

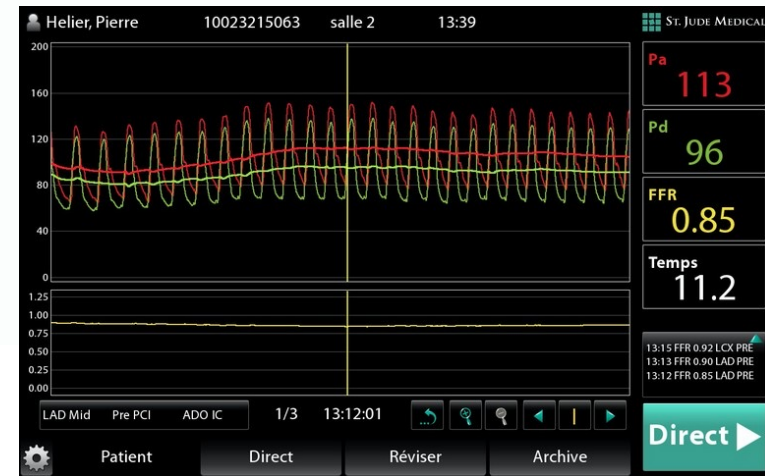
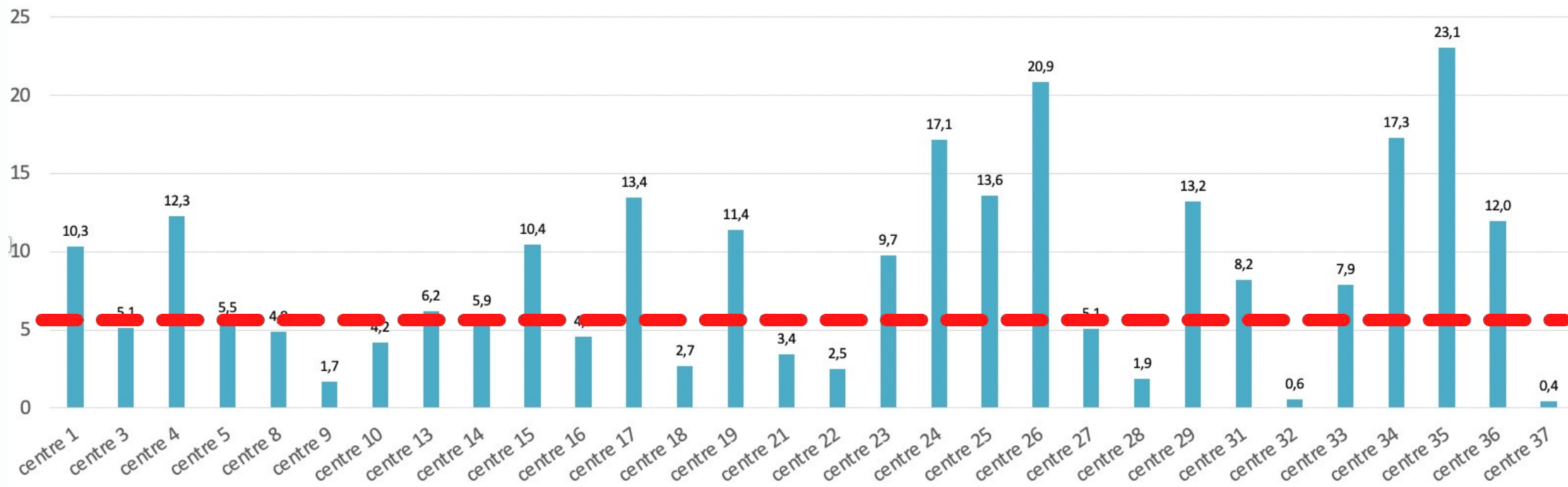


FFR

MOYENNE FPCI 2020 = 7,5 % DES ATL

SCAAR = seuil à 30 %

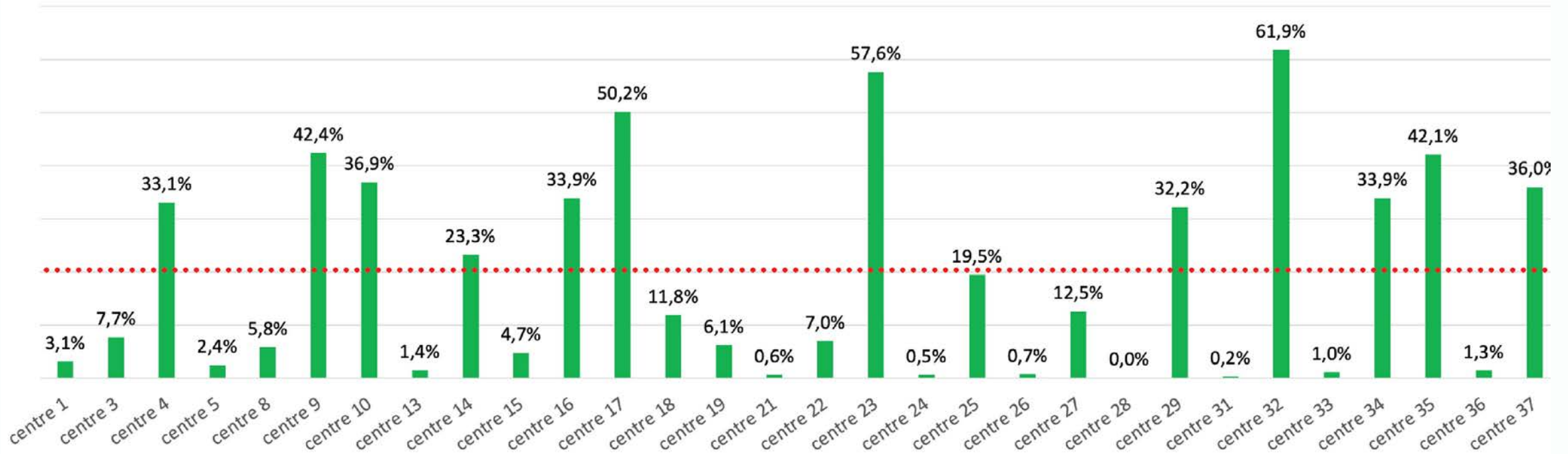
% FFR / ATL



INDICATEUR DE QUALITÉ ATL AMBULATOIRE / SCC

Moyenne = 20,8%

ATL ambulatoire / SCC



2 Rapports 2020 en ligne

100 pages de graphiques



Disponibles sur Francepci.com

Projets 2021



EXTENSION NATIONALE



APPARIEMENT SNDS

HEALTH DATA HUB



APPLI CONNECTÉE PATIENT



TRANSFERT PROMOTION ASSOCIATION CRAC VERS FPCI



Conclusions

- S'il veut dire la vérité, un registre doit être
 - de (haute) qualité
 - Porté par les spécialistes
 - Avoir un financement institutionnel
- Le registre France PCI répond à ces conditions et permet
 - D'avoir un état des lieux précis de l'activité de CI
 - De suivre l'évolution des pratiques en temps réel et permettre des alertes sanitaires
 - D'évaluer et comparer les PP (indicateurs de qualité)
 - De publier de nombreux travaux scientifiques
 - De s'apparier avec d'autres BDD (SNDS via HDH)
 - D'envisager une extension nationale à terme
- Au final d'améliorer nos pratiques et le pronostic de nos patients coronariens