16. Thromboseforum 2026

Lunchsymposium Entzündungshemmung als Schlüssel zur Risikoreduktion

Kardiovaskuläre Inflammation und Residualrisiko – warum Lipidkontrolle alleine nicht genügt

Prof. Dr.med.

Evangelos Giannitsis MD, FESC

Abteilung Innere Medizin III

Kardiologie, Angiologie, Pulmologie

Universitätsklinikum Heidelberg

Heidelberg

Conflict of Interests

Vorsitzender des Zertifizierungsgremiums für Chest Pain Units der DGK	
Associate Editor:	Clin Res Cardiol
Apontis:	Honorarium for lecture
BRAHMS Deutschland:	Honoraria for lectures and consultancy
Roche Diagnostics:	Honoraria for lectures, consultancy, research grant
Astra Zeneca:	Honoraria for lectures
Bayer Vital:	Honoraria for lectures
Daiichi Sankyo:	Honoraria for lectures, research grant
Amgen:	Honoraria for lectures
Boehringer Ingelheim:	Honoraria for lectures
Eli Lilly:	Honoraria for lectures

Klinischer Fall

Mann, 59 Jahre, 67 kg, RR 129/78 mmHg
CKD KDIGO IIIB, eGFR 45 ml/min, LV-EF 41%
RF: aHTN, Chol↑, ex-Raucher, pos. FA (Vater mit 48 Jahren MI)

- 2023 NSTEMI bei 3 VD, PCI + DES der LAD
  PTA/DEB des Tractus tibiofibularis li
  bei pAVK IIb
  ca. 70% ACI Stenose links
- 2024 NSTEMI bei de novo Stenose der prox. LCX
- 2024 IAP bei Re-stenose im Stent der LCX
- 2025 positiver Ischämienachweis im Strom-gebiet der RCA mit PCI + DES

ASS 100 1-0-0
Ticagrelor 60 1-0-1
Candesartan 16 1-0-0
Metoprolol 95 1-0-0
Dapagliflozin 10 1-0-0
Spironolacton 25 1-0-0
Torasemid 5 1-0-0
Rosuvastatin 20 0-0-1
Nustendi 180/10 1-0-0
Omega-3 1000mg 1-0-0

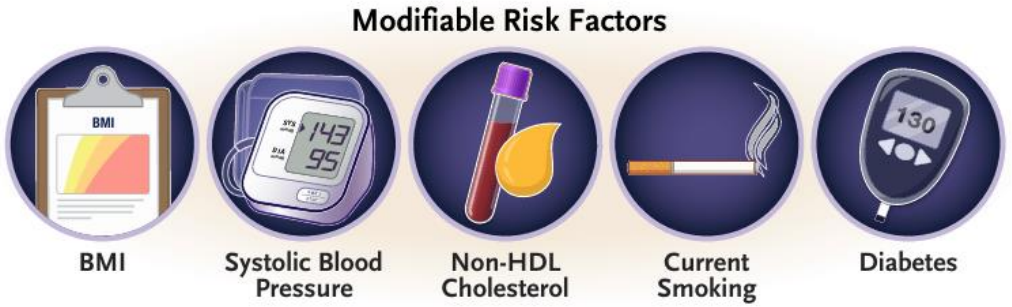
Serumkreatinin	1,4 mg/dl
eGFR	45 ml/min/1,73m2
Hs-cTnT	18 ng/L (stabil)
NT-pro BNP	175 ng/L (<125 ng/L)
Lp(a)	197 mg/dl (< 30 mg/dl)
LDL-C	170 → 75→ 56 → 32 mg/dl
Triglyzeride	149 mg/dl
Hs-CRP	**3,5 mg/dl (< 5 mg/dl)**

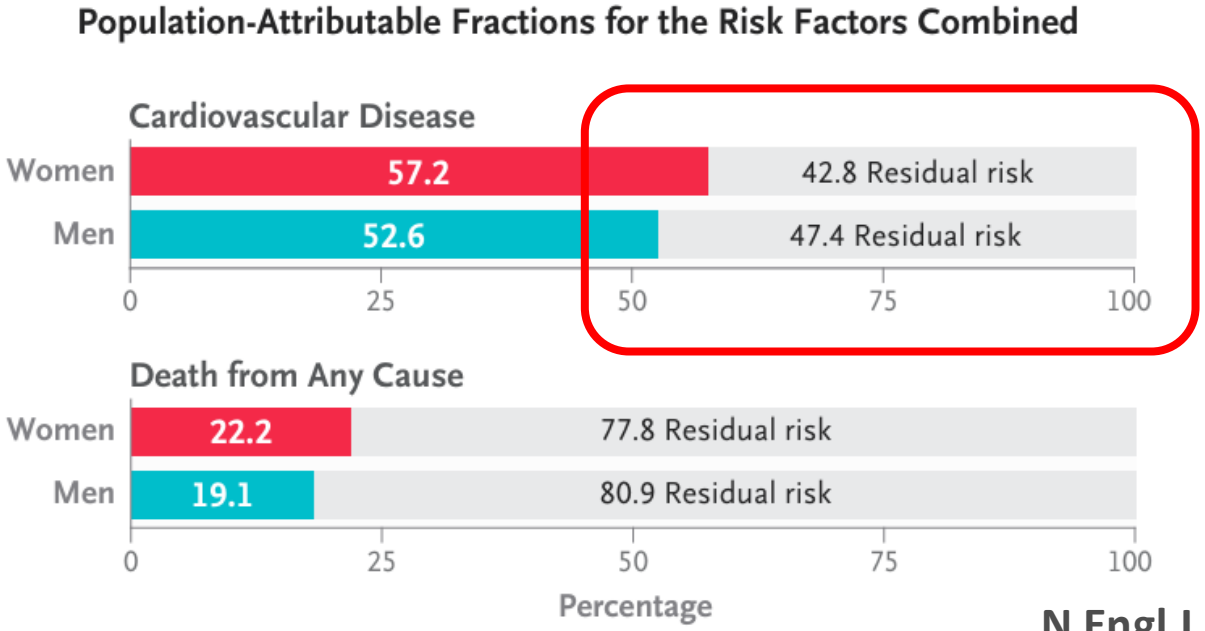
RESEARCH SUMMARY

Global Effect of Modifiable Risk Factors on Cardiovascular Disease and Mortality

Global Cardiovascular Risk Consortium DOI: 10.1056/NEJMoa2206916

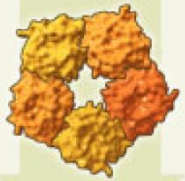
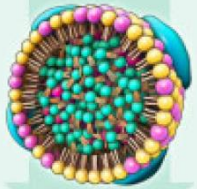
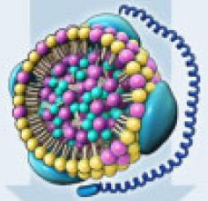
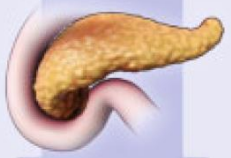
1,518,028 participants





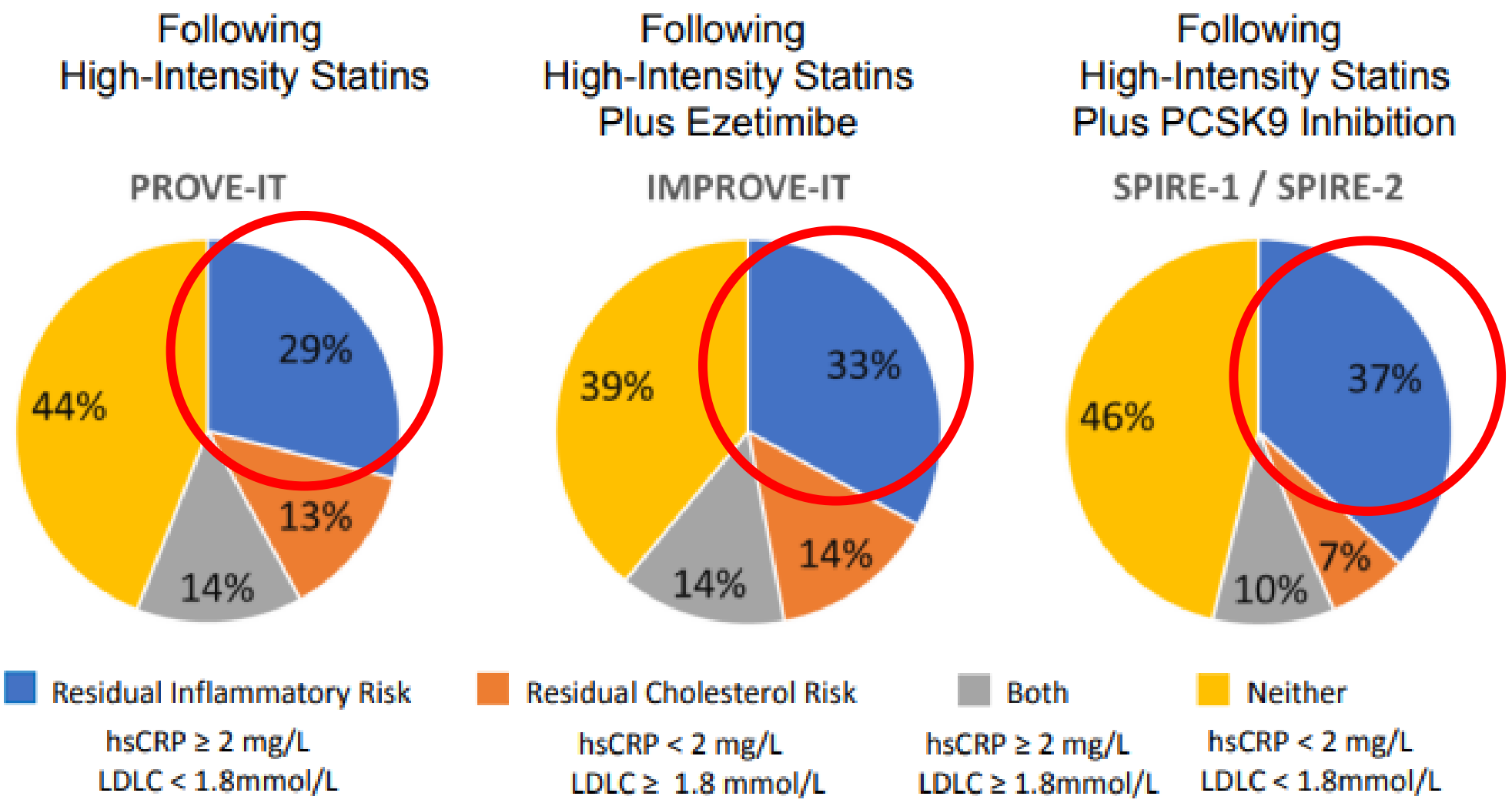
N Engl J Med 2023;389:2400-2402

Spektrum der behandelbaren Risikofaktoren

Biological Issue	Residual Cholesterol Risk	Residual Inflammatory Risk	Residual Thrombotic Risk	Residual Triglyceride Risk	Residual Lp(a) Risk	Residual Diabetes Risk
						
Critical Biomarker	LDL-C ≥100 mg/dL	hsCRP ≥2mg/L	No simple biomarker	TG ≥150mg/dL	Lp(a) ≥50mg/dL	HbA1c Fasting glucose
Potential Intervention	Targeted LDL/Apo B Reduction	Targeted Inflammation Reduction	Targeted Antithrombotic Reduction	Targeted Triglyceride Reduction	Targeted Lp(a) Reduction	SGLT2 Inhibitors GLP-1 Agonists
Randomized Trial Evidence	IMPROVE-IT FOURIER SPIRE ODYSSEY	CANTOS COLCOT *LoDoCo2* *OASIS-9*	PEGASUS COMPASS THEMIS	REDUCE-IT *PROMINENT*	Planned	EMPA-REG CANVAS DECLARE CREDENCE LEADER SUSTAIN-6 REWIND

Lawler et al., Eur Heart J 2021

How Common is Residual Inflammatory Risk?



Circulation Res 2017;120:617-9.
Pradhan et al Circulation 2018 (on line).

ESC European Society of Cardiology
European Heart Journal (2025) 00, 1–20
https://doi.org/10.1093/eurheartj/ehaf190

2025 ESC Dyslipidemias Update: Cardiovascular risk estimation: new recommendations

Recommendation Table 1 — Recommendations for cardiovascular risk estimation in persons without known cardiovascular disease

Recommendations	Class[a]	Level[b]
SCORE2 is recommended in apparently healthy people <70 years of age without established ASCVD, DM, CKD, genetic/rare lipid or BP disorders for estimation of 10-year fatal and non-fatal CVD risk.[2 c]	I	B
SCORE2-OP is recommended in apparently healthy people ≥70 years of age without established ASCVD, DM, CKD, genetic/rare lipid or BP disorders for estimation of 10-year fatal and non-fatal CVD risk.[3 c]	I	B
Presence of subclinical coronary atherosclerosis by imaging or increased CAC score by CT should be considered as risk modifiers in individuals at moderate risk or individuals around treatment decision thresholds to improve risk classification.[24,27,28,36 d]	IIa	B
Risk modifiers[e] should be considered in individuals at moderate risk or individuals around treatment decision thresholds to improve risk classification.[17,27,37 f]	IIa	B

Box 1 Risk modifiers for consideration beyond the risk estimation based on the SCORE2 and SCORE2-OP algorithms

Demographic/clinical conditions

- Family history of premature CVD (men: <55 years; women: <60 years)
- High-risk ethnicity (e.g. Southern Asian)
- Stress symptoms and psychosocial stressors
- Social deprivation
- Obesity
- Physical inactivity
- Chronic immune-mediated/inflammatory disorders
- Major psychiatric disorders
- History of premature menopause
- Pre-eclampsia or other hypertensive disorders of pregnancy
- Human immunodeficiency virus infection
- Obstructive sleep apnoea syndrome

Biomarkers

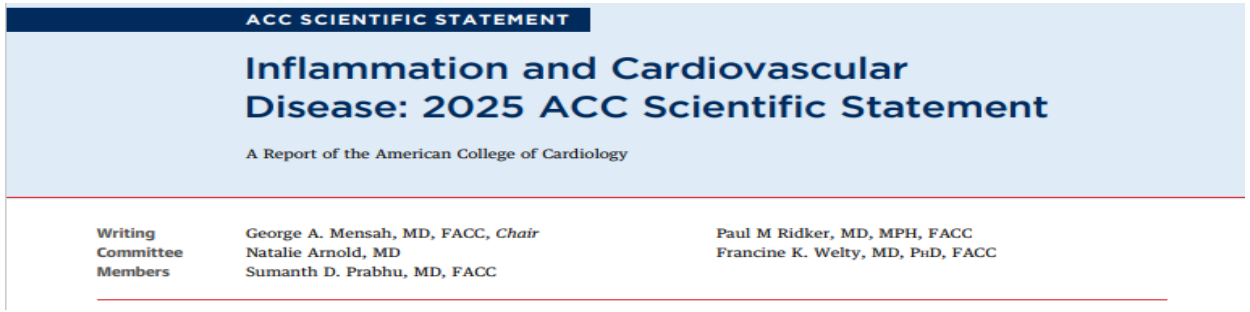
- Persistently elevated hs-CRP (>2 mg/L)
- Elevated Lp(a) [>50 mg/dL (>105 nmol/L)].

CVD, cardiovascular disease; hs-CRP, high sensitivity C-reactive protein; Lp(a), lipoprotein(a).

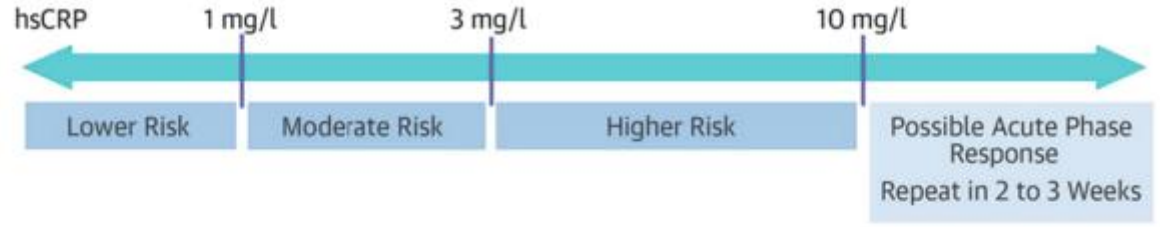
Mach F, et al. EurHeart J 2025

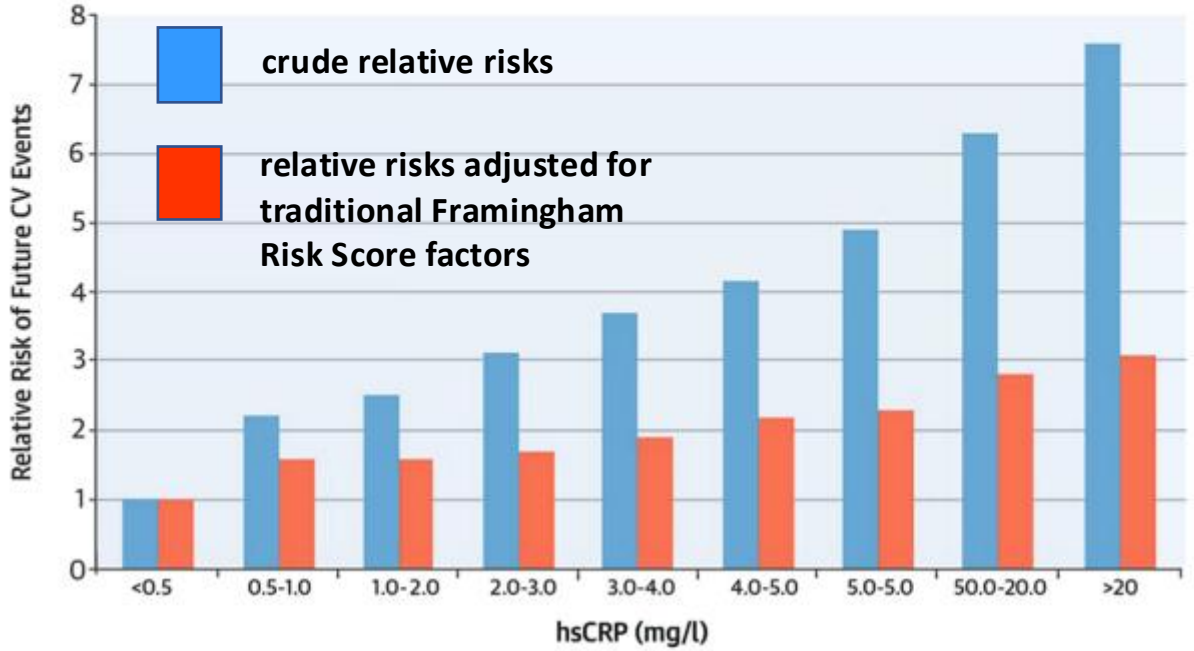
hsCRP measurement is guideline-recommended for primary prevention (Canada/USA) and in suspected ASCVD (ESC)

Guideline	Year	Categorization of hsCRP
ACC/AHA *"Primary Prevention of Cardiovascular Disease"*	2018 2019	**Risk-enhancing factor** (hsCRP ≥2.0 mg/L)
CCS *"Management of Dyslipidemia for the Prevention of Cardiovascular Disease"*	2021	**Risk modifier** (hsCRP ≥2.0 mg/L)
ESC *"Cardiovascular Disease Prevention in Clinical Practice"*	2021	**Circulating biomarker** (potential risk modifier) **But: no biomarkers recommended**
ESC *"Management of Chronic Coronary Syndromes"*	2024	**Class IIa recommendation** for measurement of hsCRP in the initial diagnostic workup in suspected CCS



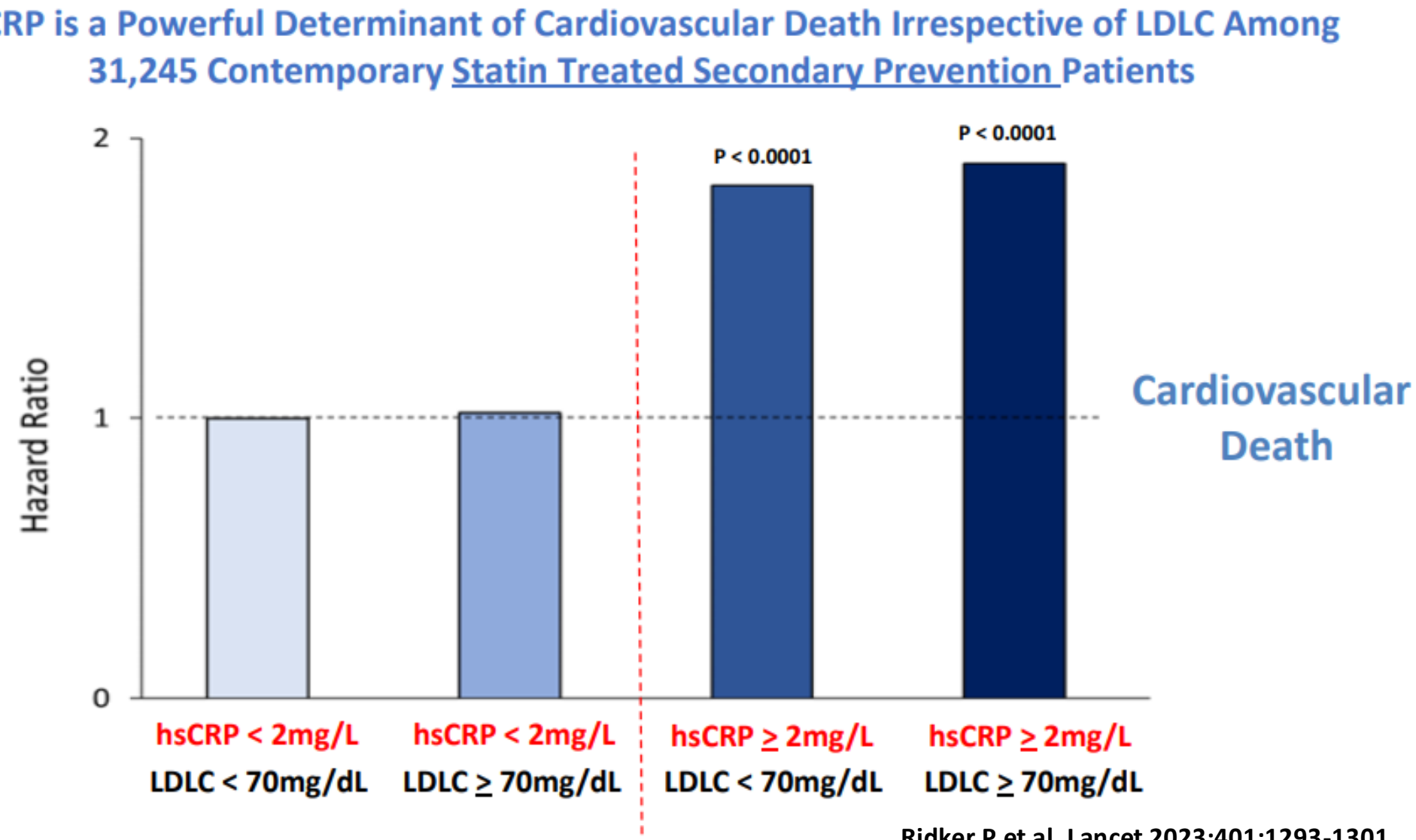
The relationship of inflammation to cardiovascular (CV) risk is linear across a wide range of high-sensitivity C-reactive protein (hsCRP) values





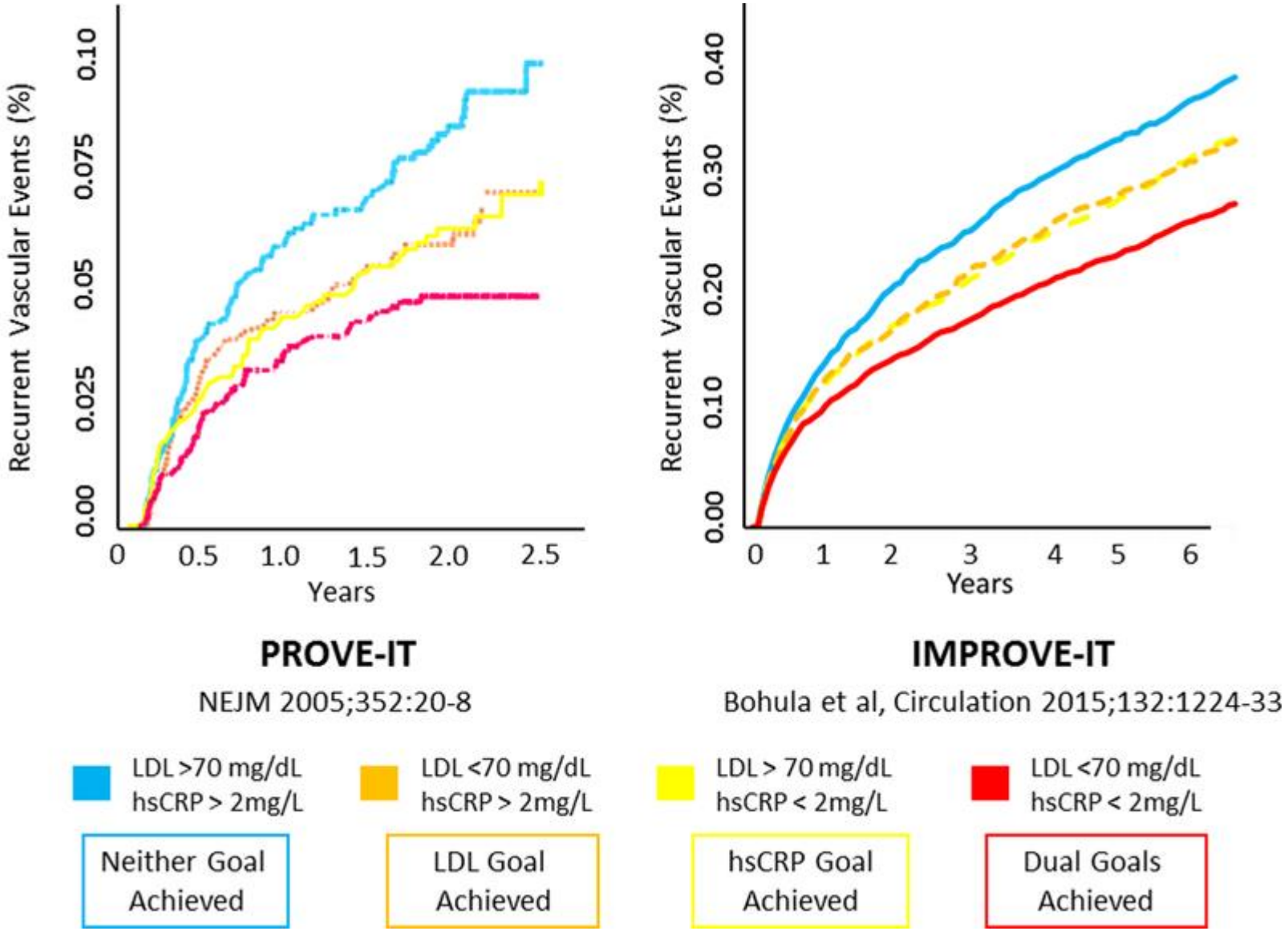
Mensah GA, et al. J Am Coll Cardiol. 2025 Sep 29:S0735-1097(25)07555-2

Rolle der Inflammation in Relation zu LDL-Cholesterin



Ridker P et al. Lancet 2023;401:1293-1301

“Dual targets” of low cholesterol and low inflammation maximizes benefit in terms of absolute risk reduction

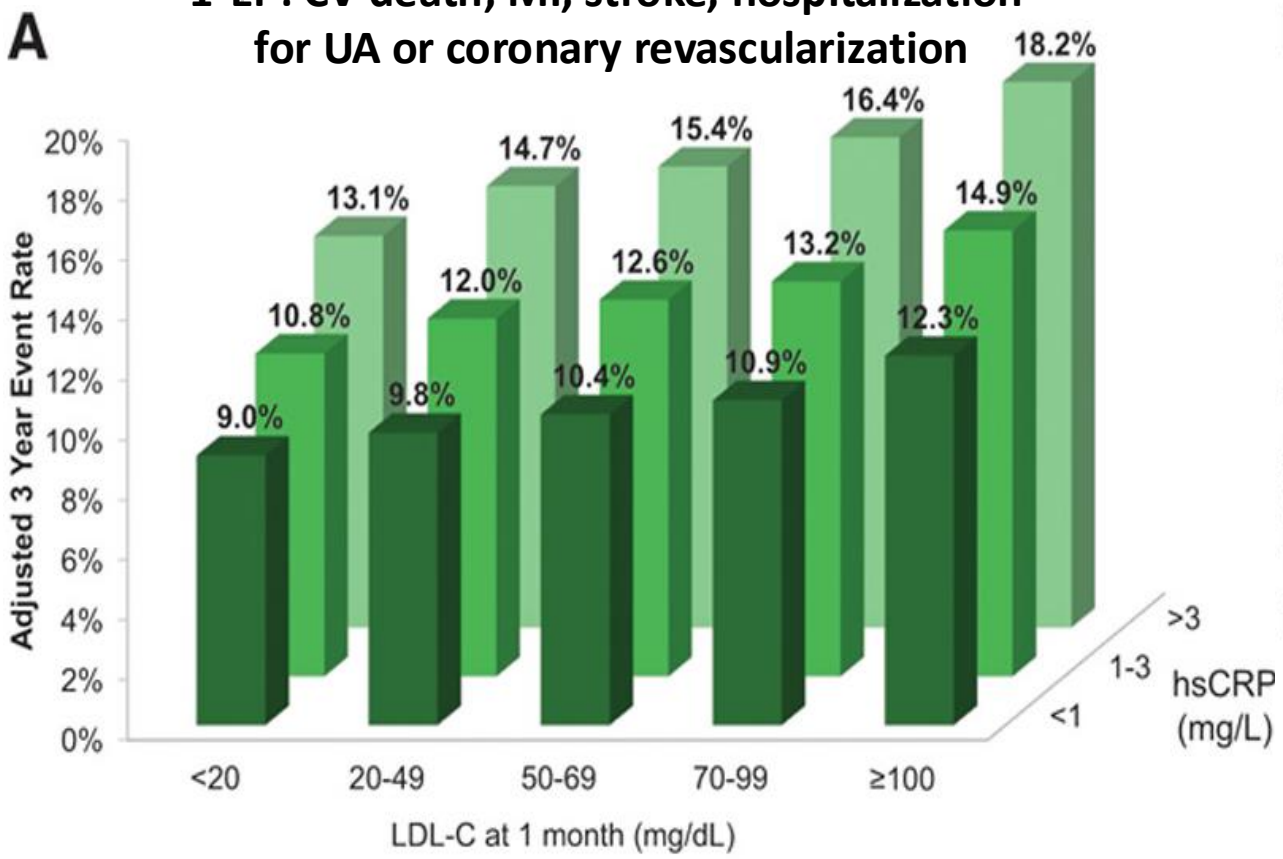


Ridker et al, N Engl J Med 2005; 352:20–8

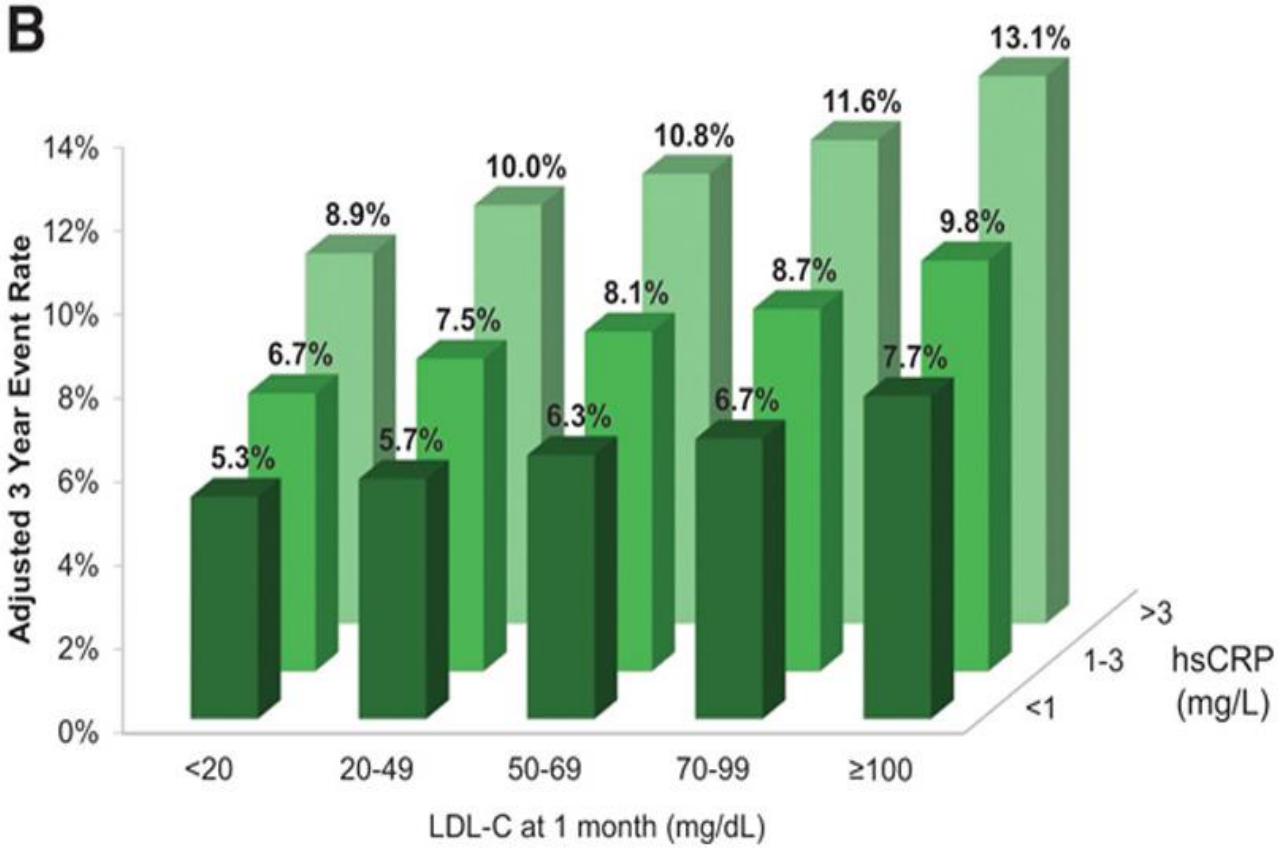
Bohula et al Circulation 2015; 132:1224–33

FOURIER: Residual Inflammatory Risk is Present Irrespective of On-Treatment LDL-C

1°EP: CV death, MI, stroke, hospitalization for UA or coronary revascularization



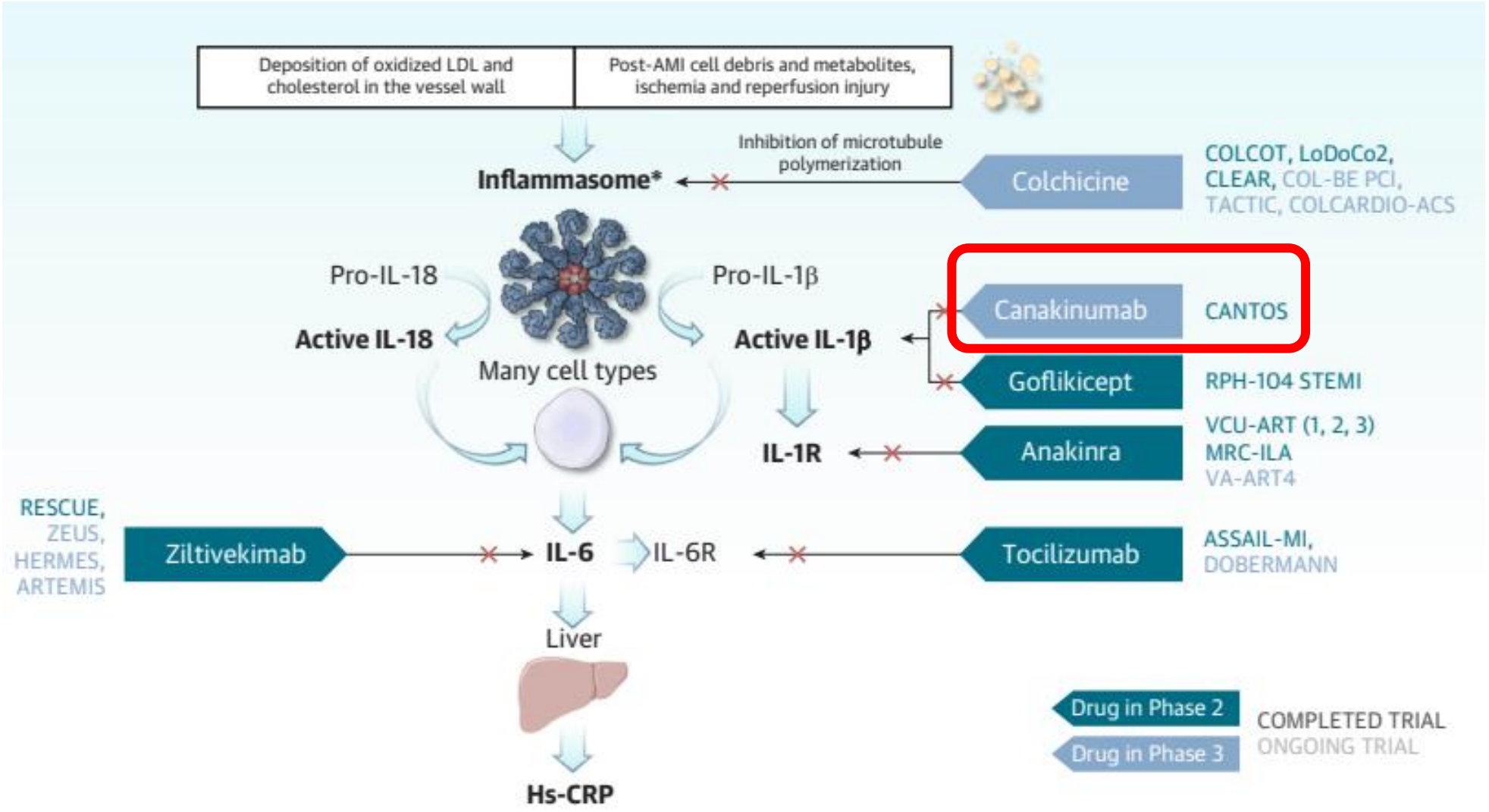
2°EP: CV death, MI, stroke



Bohula E. Circulation 2018. DOI: 10.1161/CirculationAHA. 118.034032

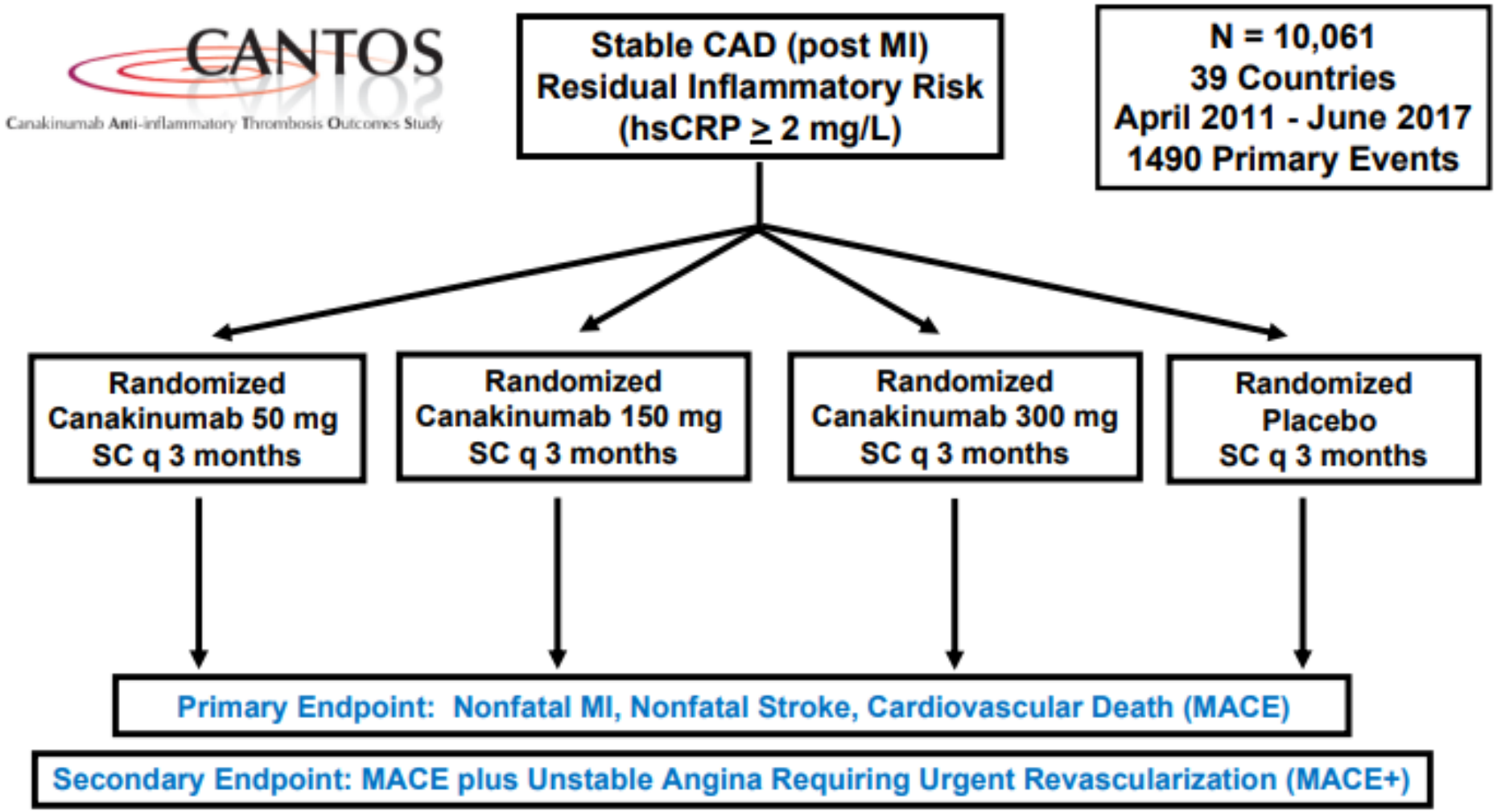
Bohula E, et al. Circulation. 2018 Jul 10;138(2):131-140.

Molecular Targets of Inflammation in AMI and Investigational Anti-Inflammatory Drugs



Imbesi A, et al. JACC. 2025;86(15):1146–1169.

Canakinumab Anti-inflammatory Thrombosis Outcomes Study (CANTOS)



"Residual Inflammatory Risk"

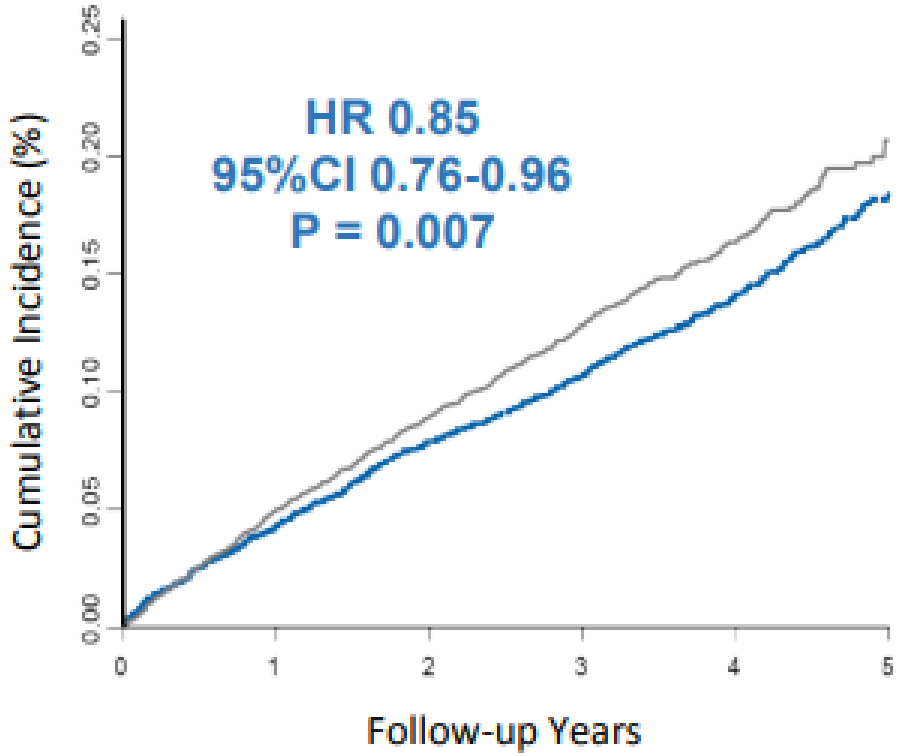
Baseline LDLC 82mg/dL (2.1mmol/L) but hsCRP 4.1 mg/L

Ridker PM et al. N Engl J Med. 2017;377:1119-31

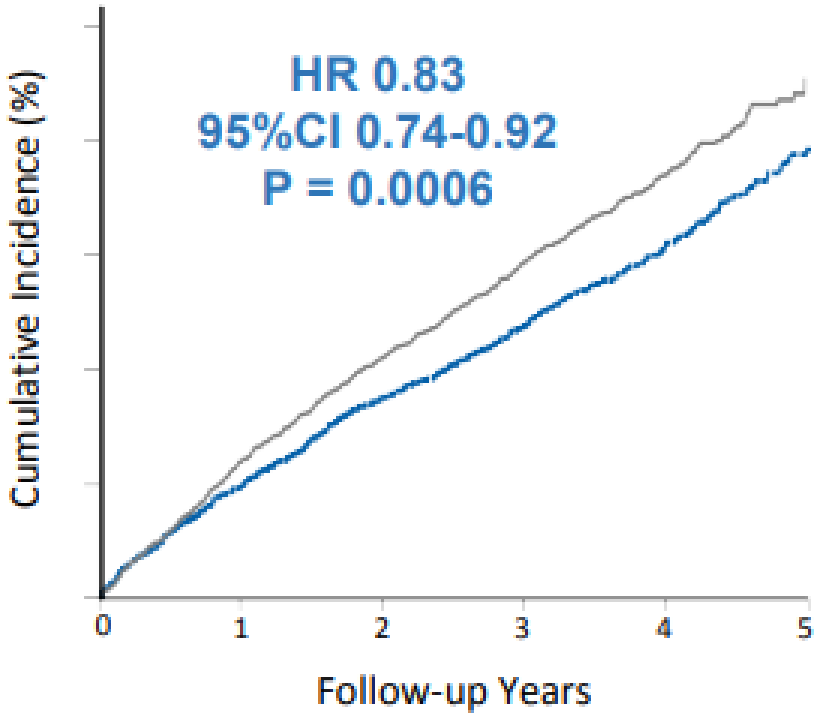
CANTOS: Primary Cardiovascular Endpoints

Placebo SC q 3 months
Canakinumab 150/300 mg SC q 3 months

MACE



MACE - Plus

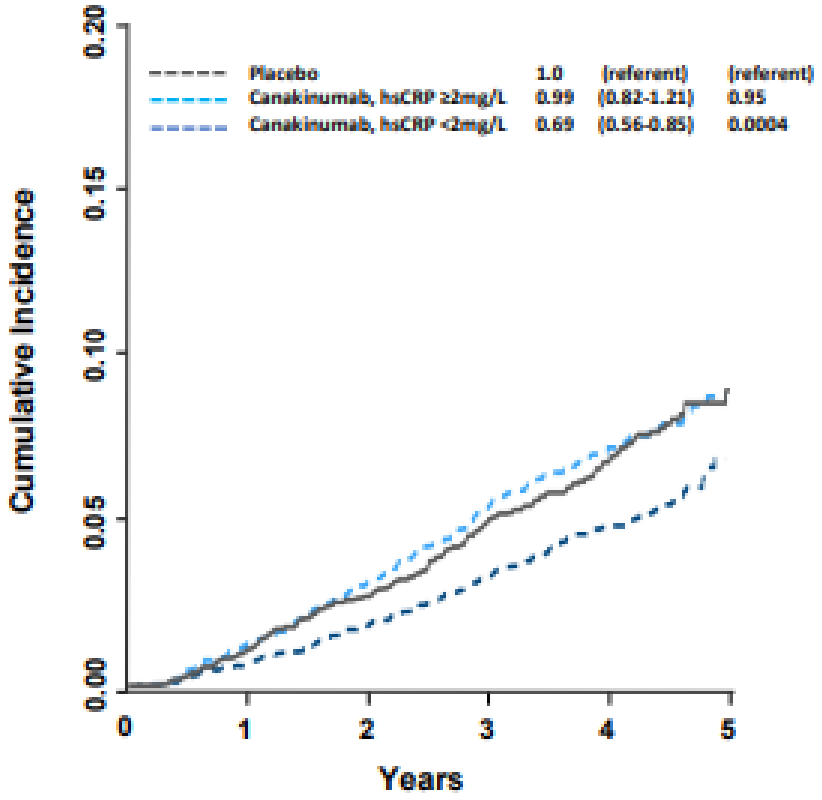


35 - 40% reductions in hsCRP and IL-6
No change in LDLC

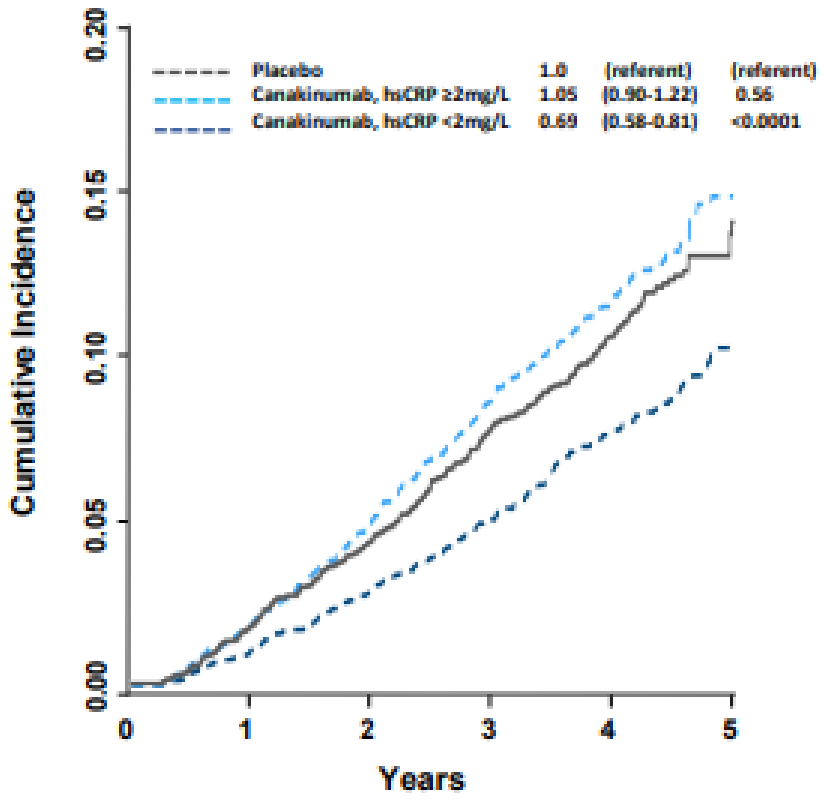
Ridker PM et al. N Engl J Med. 2017;377:1119-31

CANTOS : 31% Reduction in Cardiovascular Mortality and All-Cause Mortality Among Participants with Robust Inhibition of the Inflammatory Response

CANTOS - Cardiovascular Mortality



CANTOS - All Cause Mortality

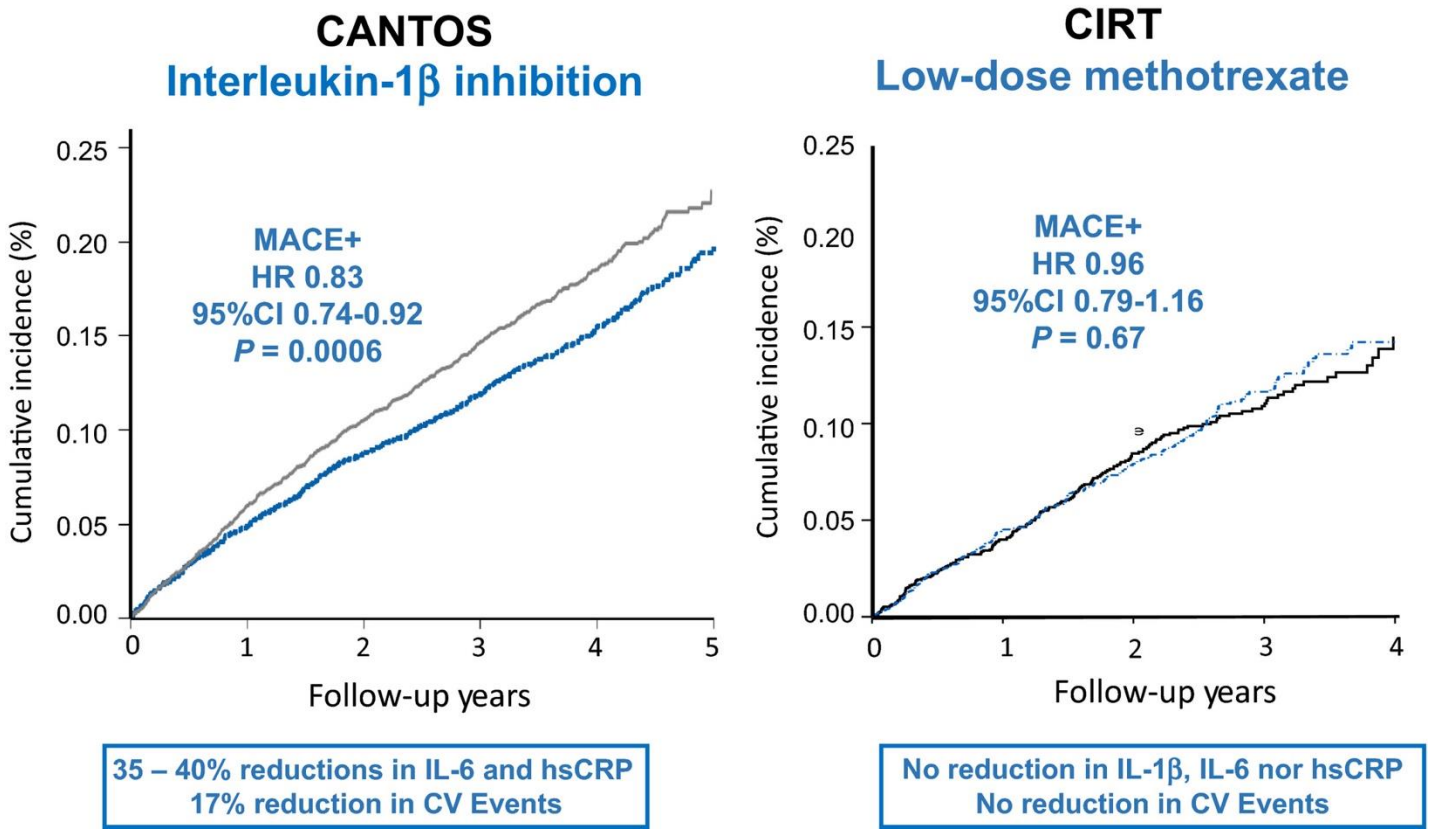


35 - 40% reductions in hsCRP and IL-6
No change in LDLC

Ridker PM Circulation 2018;137:1763-1766

Anti-inflammatory therapy for atherosclerosis: interpreting divergent results from the CANTOS and CIRT clinical trials

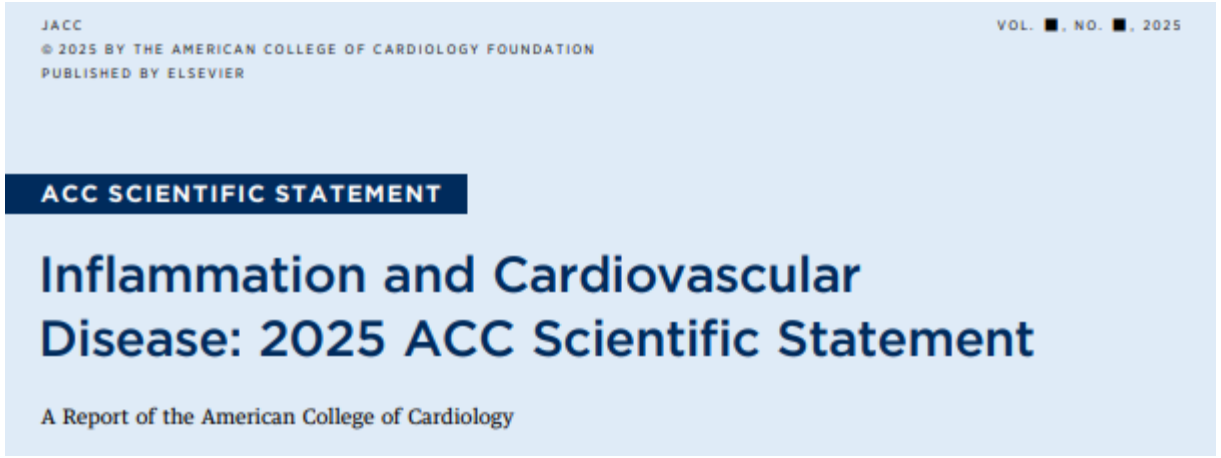
Recurrent MI, stroke, need for urgent revascularization, or CV death (MACE-plus)



The CIRT data suggest that the mechanism of low-dose methotrexate, likely mediated through adenosine signalling [13, 14], comprises an entirely different pathway for inflammation inhibition that is less relevant for atherothrombosis.

Ridker PM. J Intern Med. 2019 May;285(5):503-509.

2025 ACC Scientific Statement Consensus Recommendations on hsCRP screening and anti-inflammatory approaches in secondary prevention



hsCRP screening and anti-inflammatory approaches in secondary prevention

- Among individuals with known cardiovascular disease both treated and not treated with statins, hsCRP is **at least as powerful** a predictor of recurrent vascular events **as** that of **LDL cholesterol**, demonstrating the importance of "residual inflammatory risk" in contemporary practice.
- Among individuals taking statin therapy, consideration should be given to increase dosage into the **higher intensity range** if **hsCRP** levels remain **>2 mg/L**, irrespective of LDL cholesterol.
- **Low-dose colchicine** reduces cardiovascular events among individuals with chronic stable atherosclerosis and is **the first FDA approved anti-inflammatory agent** for this purpose.
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Mensah GA, et al. J Am Coll Cardiol. 2025 Sep 29:S0735-1097(25)07555-2

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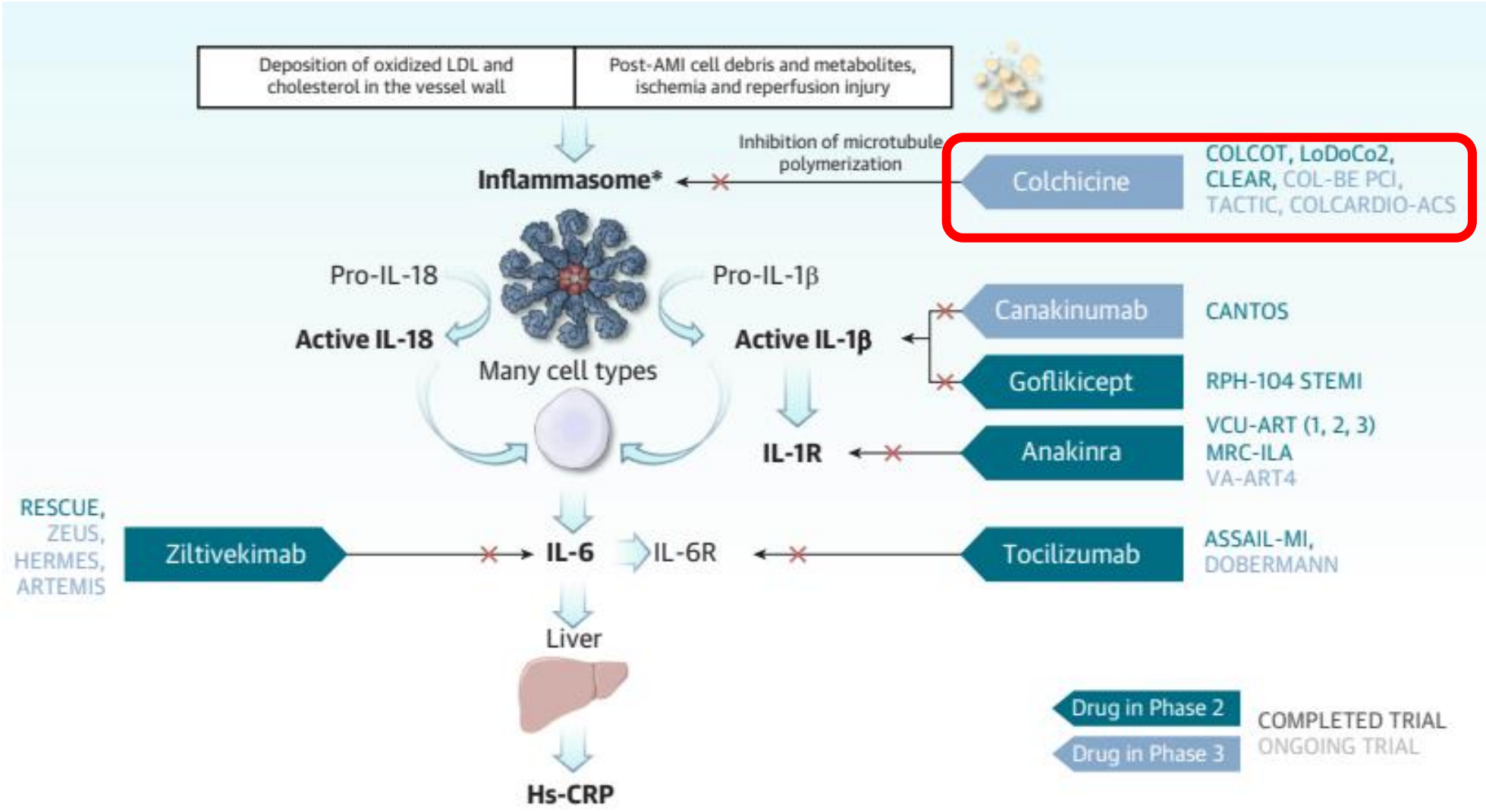
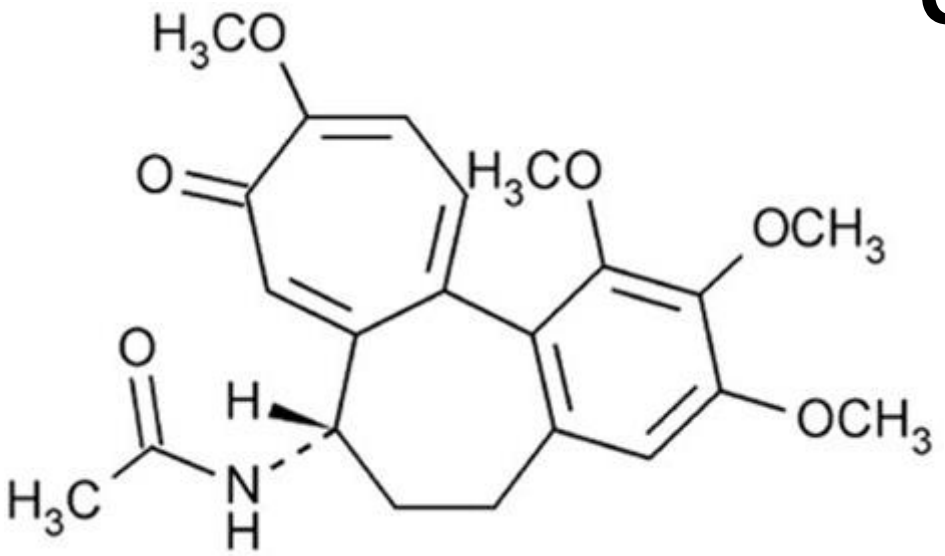


Imbesi A, et al. JACC. 2025;86(15):1146–1169.

Colchicine



- Extracted from the autumn crocus („Herbstzeitlose“)
- Relatively inexpensive
- Oral administered
- Historically indicated for the treatment of gout, familial Mediterranean Fever, and pericarditis

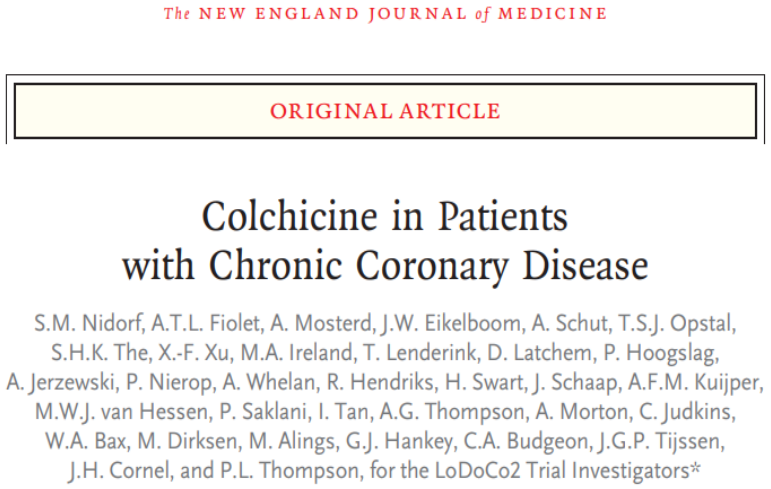
Caveats

- Potential for drug-to drug interactions, particularly with strong CYP3A4 and P-glycoprotein inhibitors
- Most common AE are diarrhea, nausea, abdominal pain in up to 10% of those initiating therapy
- Renally and hepatically metabolized

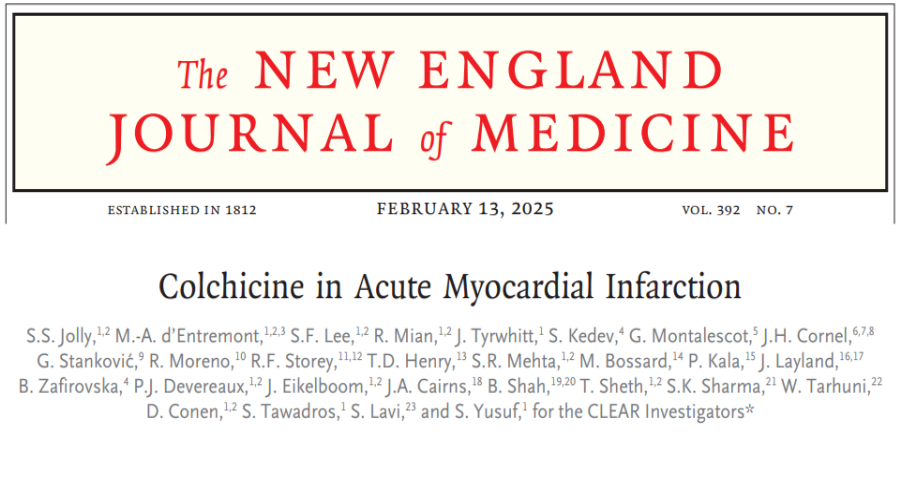
Key Publications on Colchicine in CAD with MI

COLCOT

LoDoCo



CLEAR



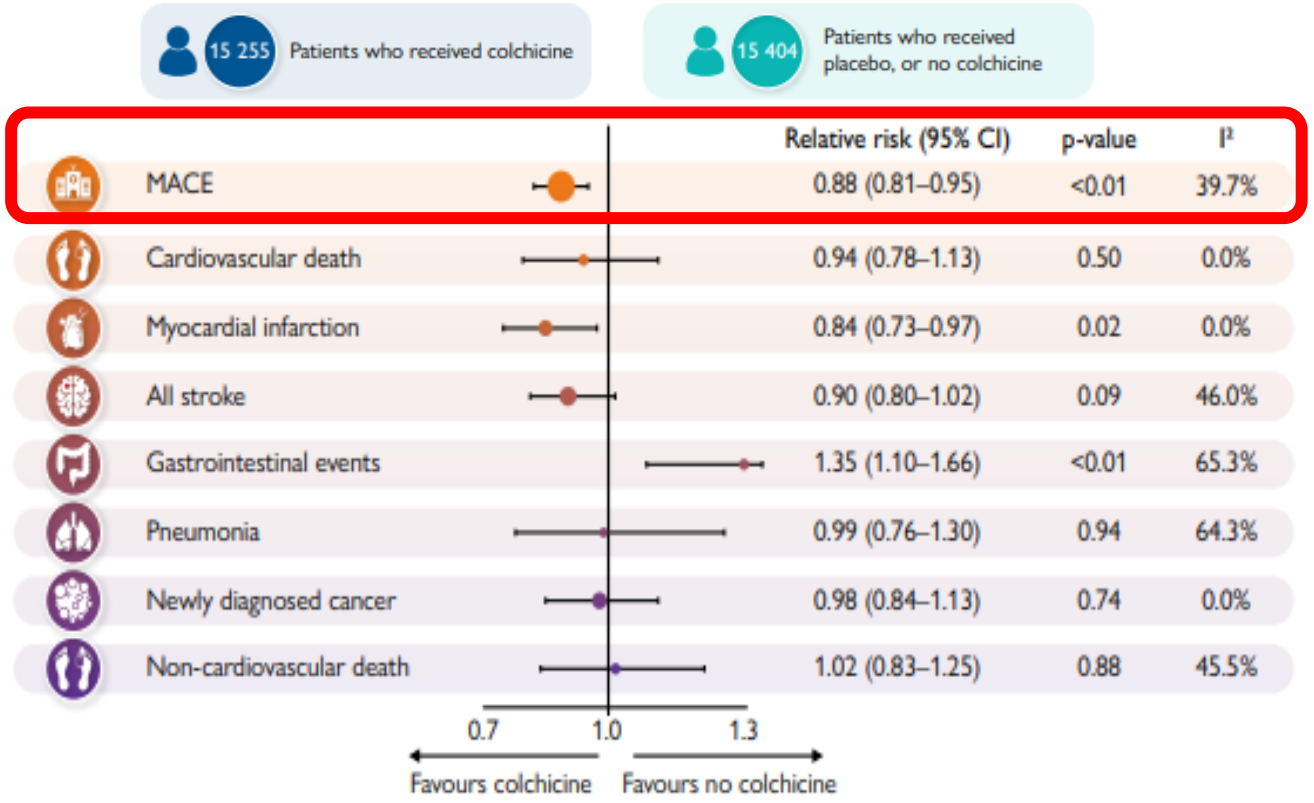
Engl J Med 2019;381:2497-505

N Engl J Med 2020;383:1838-47.

N Engl J Med 2025;392:633-42

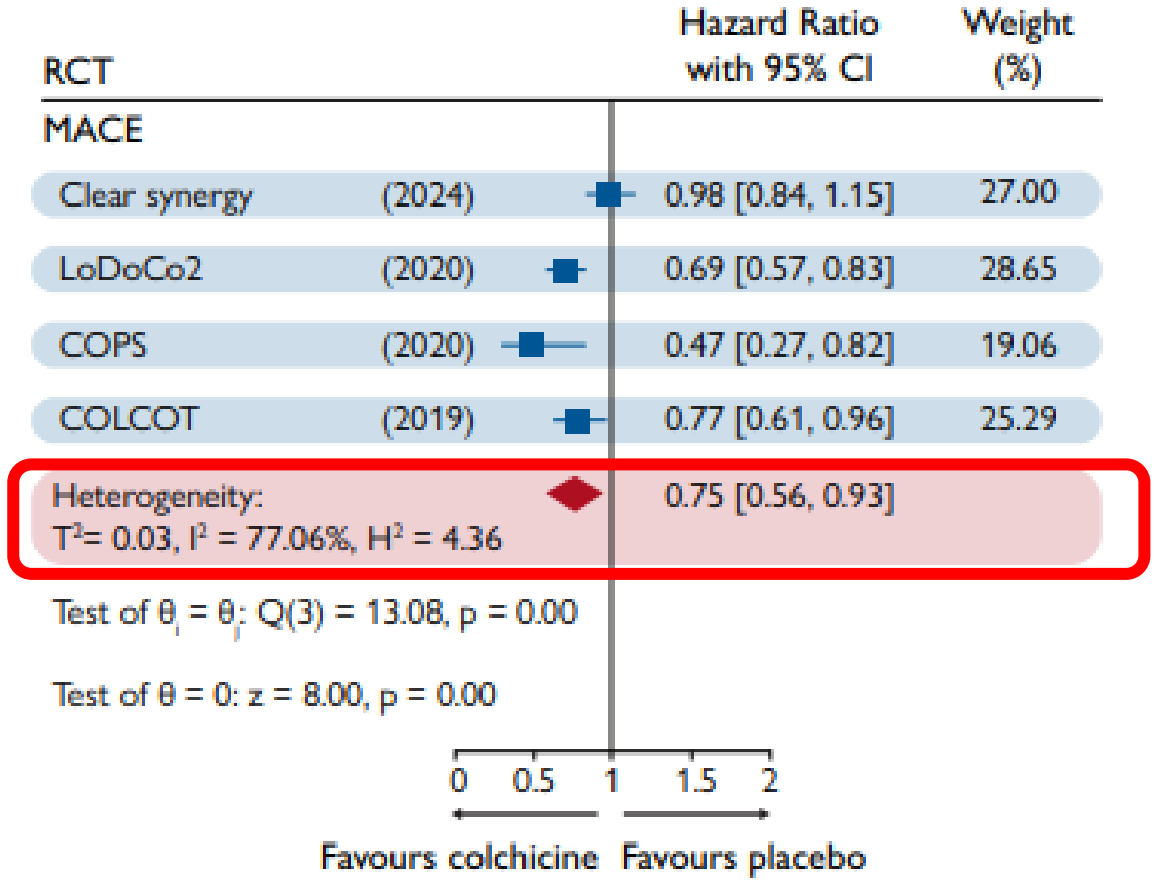
Colchicine for secondary prevention of vascular events: 2 new meta-analyses

Colchicine for secondary prevention of vascular events: a meta-analysis on 9 trials, 30 659 patients



d'Entremont MA, et al. Eur Heart J. 2025 Jul 7;46(26):2564-2575

Long-term trials of colchicine for secondary prevention of vascular events: a meta-analysis on 6 RCTs, 21 800 patients, FU 12–34 months



Samuel M, et al. Eur Heart J. 2025 Jul 7;46(26):2552-2563

COLCOT: good tolerance

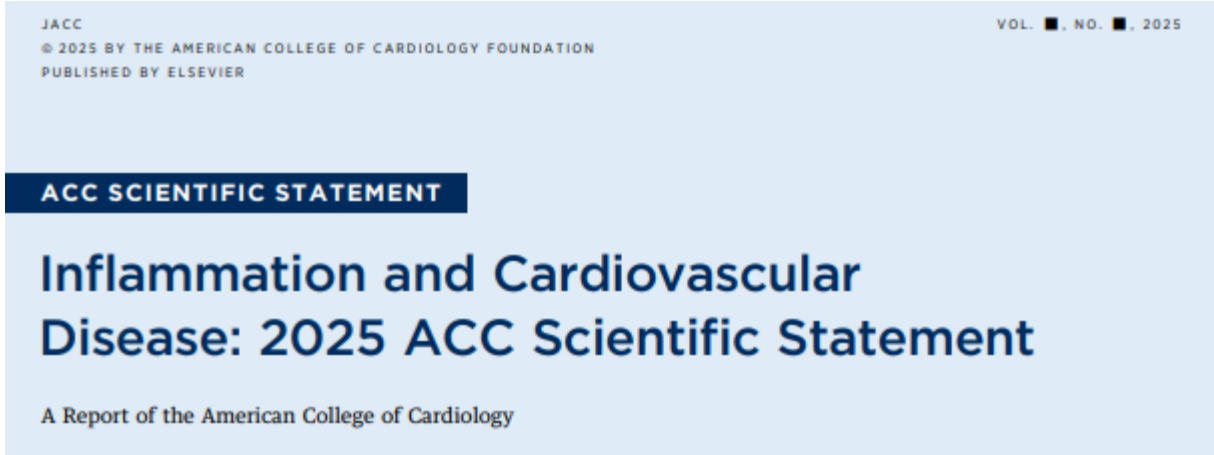
Adverse events

COLCOT

Safety population	Colchicine (N=2330)	Placebo (N=2346)	P Value
Any related AE - no. (%)	372 (16.0%)	371 (15.8%)	0.89
Any SAE - no. (%)	383 (16.4%)	404 (17.2%)	0.47
Gastro-intestinal AE - no. (%)	408 (17.5%)	414 (17.6%)	0.90
Gastro-intestinal SAE – no. (%)	46 (2.0%)	36 (1.5%)	0.25
Diarrhea AE - no. (%)	225 (9.7%)	208 (8.9%)	0.35
Nausea AE - no. (%)	43 (1.8%)	24 (1.0%)	0.02
Flatulence AE - no. (%)	15 (0.6%)	5 (0.2%)	0.02
GI haemorrhage AE - no. (%)	7 (0.3%)	5 (0.2%)	0.56
Infection SAE - no. (%)	51 (2.2%)	38 (1.6%)	0.15
Pneumonia SAE - no. (%)	21 (0.9%)	9 (0.4%)	0.03
Septic shock SAE - no. (%)	2 (0.1%)	2 (0.1%)	0.99
HF hospitalization - no. (%)	25 (1.1%)	17 (0.7%)	0.21
Cancer - no. (%)	43 (1.8%)	46 (2.0%)	0.77
Anemia - no. (%)	14 (0.6%)	10 (0.4%)	0.40
Leukopenia - no. (%)	2 (0.1%)	3 (0.1%)	0.66
Thrombocytopenia - no. (%)	3 (0.1%)	7 (0.3%)	0.21

Tardif, JC.,... Roubille, F.
N Engl J Med. 2019 Dec 26;381(26):2497-2505.

2025 ACC Scientific Statement Consensus Recommendations on hsCRP screening and anti-inflammatory approaches in secondary prevention



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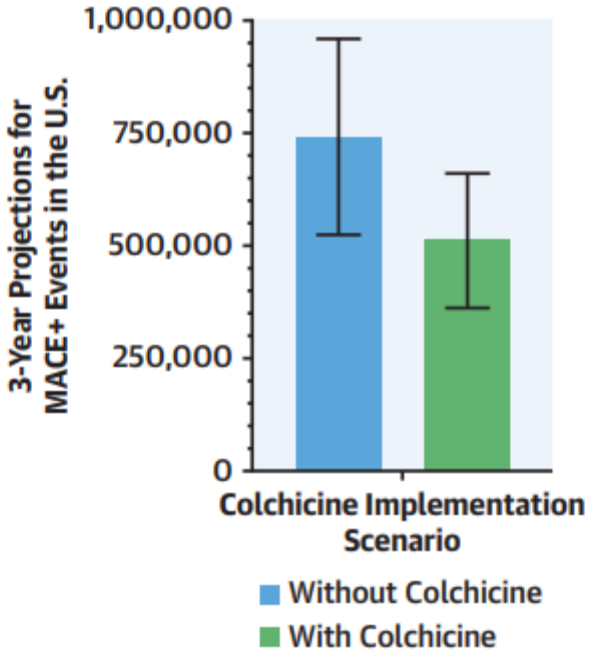
Mensah GA, et al. J Am Coll Cardiol. 2025 Sep 29:S0735-1097(25)07555-2

Potential Impact of Colchicine on ACVD in the United States

Underuse of Colchicine

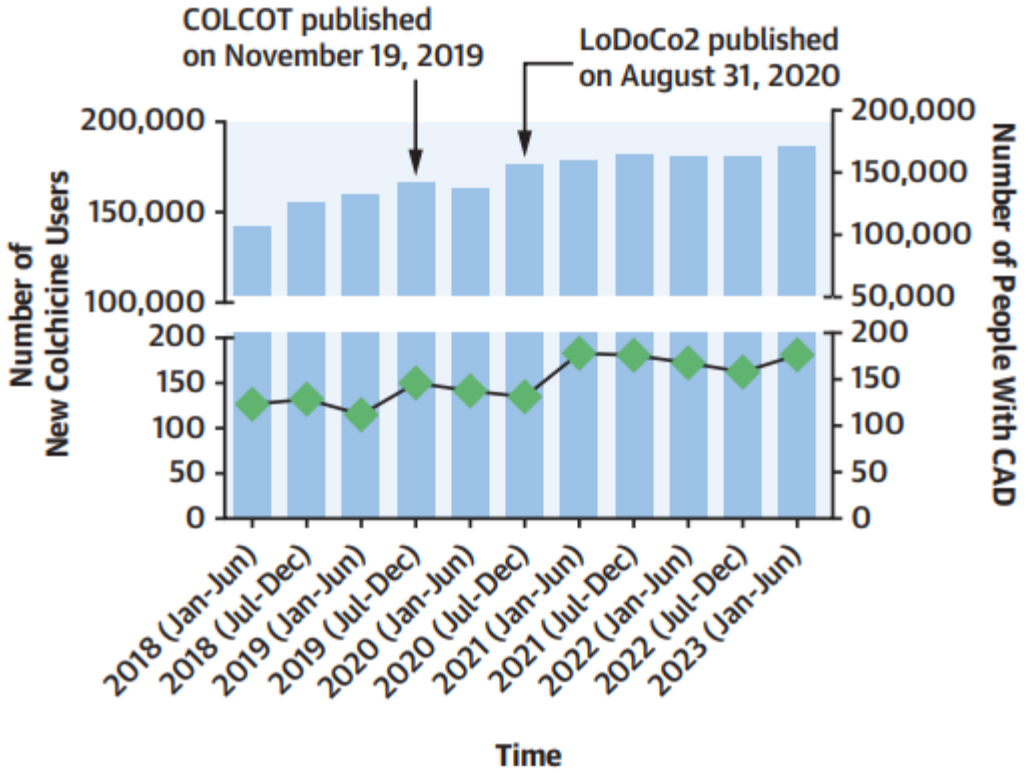
Numbers of potentially avoidable MACEs calculated by extrapolation of the risk reduction from the LoDoCo2 trial and the nationally representative National Health And Nutrition Examination Survey study

Routine Colchicine Use May Prevent 226,000 Major Adverse Cardiovascular Events in the United States Over a 3-Year Period



Data on Colchicine use before and after major publications in an integrated health care system in southeastern New England from 2018 to 2023

<1% of Patients With Coronary Artery Disease at an Academic Health System



Buckley LF, et al. JACC Adv. 2025;4(3):101622.

FDA Approval of low dose colchicine 0.5 mg po

FDA approves colchicine, the first anti-inflammatory drug for treating cardiovascular disease

----------INDICATIONS AND USAGE----------

LODOCO is an alkaloid indicated:

- to reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular disease (1).

----------DOSAGE AND ADMINISTRATION----------

The recommended dosage is 0.5 mg orally once daily. (2.1).

Bundesinstitut
für Arzneimittel
und Medizinprodukte

Zulassung Colchicin 0,5 mg QD für Sekundärprävention

Allgemeine Angaben

BfArM: AMIce-ÖFF/ Arzneimittel © BfArM

Eingangsnummer	7010105
Arzneimittelbezeichnung	Colxi 0,5 mg Filmtabletten
Anzahl der Wirkstoffe im AM	1
Berechnete Stärke	0.5 mg
Darreichungsform	Filmtablette
Zielgruppe (Domain)	Mensch
Status der Version	CURRENT
Hauptversionsnummer	7.0.0
Regulatorische Aktivität	Änderung Typ IAIN
Datensatz zuletzt aktualisiert am	08.01.2026

Anwendungsgebiete

Anwendungsgebiete	Erwachsene Prophylaxe von ischämischen kardiovaskulären Ereignissen bei Patienten mit atherosklerotischer koronarer Herzerkrankung und vor kurzem stattgefundenem Myokardinfarkt (MI) zusätzlich zu Standardtherapien.

Zulassungsinformationen

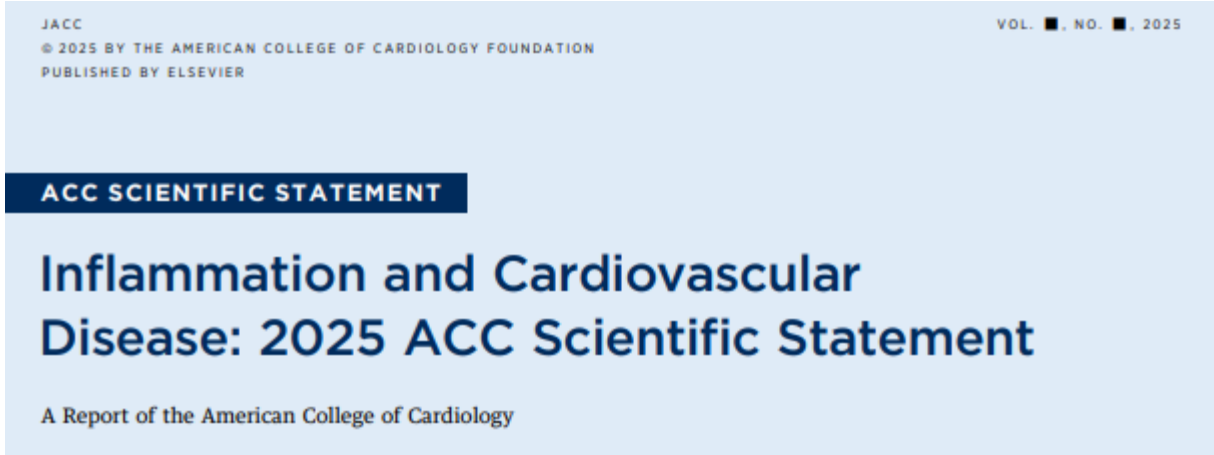
Zulassungsnummer/ Registrierungsnummer	7010105.00.00
Datum der Zulassung/Registrierung (Wirksamkeitsdatum)	02.08.2025
Verfahrenstyp	DCP - europäisches dezentrales Verfahren
Antragsart	Zulassung gem. Art. 8(3) RL 2001/83 ("Full Dossier")
Arzneimitteltyp	Chemisches Arzneimittel
Status	zugelassen

Bei Patienten mit bestätigter koronarer Herzerkrankung wird die Behandlung innerhalb von 3 Tagen, spätestens jedoch 30 Tage nach einem Myokardinfarkt eingeleitet. Die Höchstdosis ist 0,5 mg täglich*.

*https://www.fachinfo.de/fi/pdf/025606/colxi-0-5-mg-filmtabletten

https://portal.dimdi.de/amguifree/am/docoutput/jpadocdisplay.xhtml?globalDocId=820F9F50389C43238F4DE5FBB9523ACA&directdisplay=true&docid=1

2025 ACC Scientific Statement Consensus Recommendations on hsCRP screening and anti-inflammatory approaches in secondary prevention



hsCRP screening and anti-inflammatory approaches in secondary prevention

- Among individuals with known cardiovascular disease both treated and not treated with statins, hsCRP is **at least as powerful** a predictor of recurrent vascular events **as** that of **LDL cholesterol**, demonstrating the importance of "residual inflammatory risk" in contemporary practice.
- Among individuals taking statin therapy, consideration should be given to increase dosage into the **higher intensity range** if **hsCRP** levels remain **>2 mg/L**, irrespective of LDL cholesterol.
- **Low-dose colchicine** reduces cardiovascular events among individuals with chronic stable atherosclerosis and is **the first FDA approved anti-inflammatory agent** for this purpose.
- **Low-dose colchicine** is intended to be used as an **adjunct to lipid lowering**; however, colchicine has not proven effective when initiated at the time of acute ischemia and should be avoided among individuals with significant liver or renal disease.
- Several **novel anti-inflammatory agents**, including IL-6 inhibitors, are now being evaluated in **ongoing randomized trials** in the settings of chronic kidney disease, dialysis, HFpEF, and acute coronary syndrome

Mensah GA, et al. J Am Coll Cardiol. 2025 Sep 29:S0735-1097(25)07555-2

Overview of Ongoing Randomized Controlled Trials of Anti-Inflammatory Drugs Across the Spectrum of CAD

Trial (Phase)	Population	Sample Size	Time of Intervention	Primary Endpoint	Follow-Up	Study Completion
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Imbesi A, et al. JACC. 2025;86(15):1146–1169.

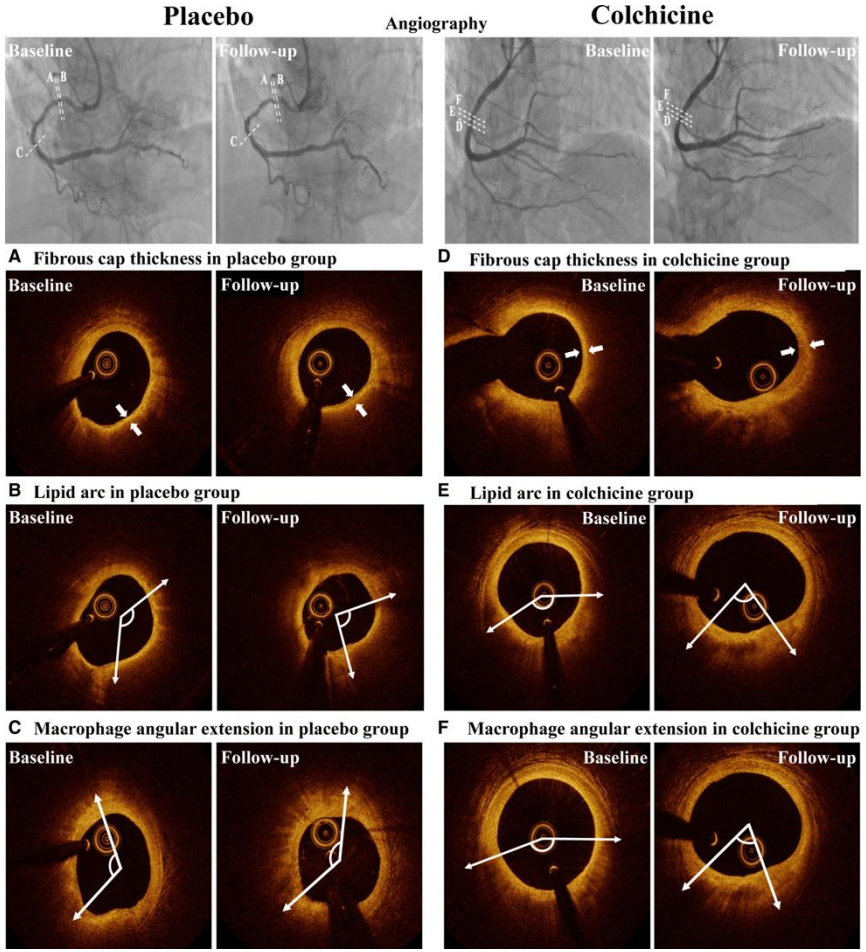
Backup

Circulation
Volume 150, Issue 13, 24 September 2024; Pages 981-993
https://doi.org/10.1161/CIRCULATIONAHA.124.069808

ORIGINAL RESEARCH ARTICLE

Effect of Colchicine on Coronary Plaque Stability in Acute Coronary Syndrome as Assessed by Optical Coherence Tomography: The COLOCT Randomized Clinical Trial

N=104; Placebo=52



	Baseline		12-Mo follow-up		Change from baseline to 12 mo		Difference in change	*P* value
	Placebo (n=64)	Colchicine (n=64)	Placebo (n=52)	Colchicine (n=52)	Placebo (n=52)	Colchicine (n=52)		
Plaque numbers	138	167	108	131	108	131		
Primary end point								
Minimal fibrous cap thickness, μm*	130.9±70.2	139.6±76.0	185.4±90.6	227.8±124.4	51.9 (32.8 to 71.0)	87.2 (69.9 to 104.5)	34.2 (9.7 to 58.6)	0.006
Secondary end point								
Minimum lumen area, mm^2	5.1±2.5	4.5±2.3	4.5±2.3	4.2±2.4	−0.3 (−0.5 to −0.1)	−0.2 (−0.4 to −0.1)	0.1 (−0.1 to 0.4)	0.387
Average lipid arc, °	105.1±28.6	109.0±29.6	79.8±25.4	73.0±31.5	−25.2 (−30.6 to −19.9)	−35.7 (−40.5 to −30.8)	−10.5 (−17.7 to −3.4)	0.004
Mean macrophage angular extension, °	38.9±25.7	43.2±27.1	32.5±16.6	30.1±16.9	−8.9 (−13.3 to −4.6)	−14.0 (−18.0 to −10.0)	−6.0 −11.8 to −0.2)	0.044
Thin-cap fibroathero-ma incidence, n (%)†	32 (23.2%)	35 (21.0%)	14 (13.0%)	11 (8.4%)	−10.2% (−19.4 to −1.1)	−12.6% (−4.6 to −20.5)	OR, 0.8 (0.5 to 1.3)	0.367

favorable effects on coronary plaque stabilization at OCT

Yu M, et al. Circulation. 2024 Sep 24;150(13):981-993.

Colchicine on Coronary Plaque Stability in Acute Coronary Syndrome

Optical Coherence Tomography - The COLOCT Randomized Clinical Trial

Inflammatory Biomarkers at Baseline and Follow-Up

	Baseline		12-Mo follow-up		Absolute value change from baseline to 12 mo			
	Placebo (n=64)	Colchicine (n=64)	Placebo (n=52)	Colchicine (n=52)	Placebo (n=52)	Colchicine (n=52)	Difference in change	*P* value
hsCRP, mg/L	1.1 (0.4, 4.4)	1.2 (0.5, 5.6)	0.6 (0.2, 1.3)	0.5 (0.2, 1.3)	0.6 (0.4 to 1.0)	0.3 (0.2 to 0.5)	0.5 (0.3 to 1.0)	0.046
IL-1RA, pg/mL	95.3 (62.4, 143.7)	105.6 (75.9, 148.7)	91.9 (55.0, 168.5)	62.4 (42.6, 136.8)	1.0 (0.9 to 1.2)	0.7 (0.6 to 0.9)	0.7 (0.6 to 0.9)	0.003
IL-18, pg/mL	24.6 (14.4, 59.3)	26.1 (16.2, 40.5)	20.5 (11.5, 46.7)	14.5 (9.3, 20.2)	1.0 (0.8 to 1.3)	0.6 (0.4 to 0.7)	0.6 (0.4 to 0.8)	0.001
IL-6, pg/mL	5.8 (2.7, 17.2)	6.5 (3.0, 12.2)	4.5 (3.0, 11.5)	2.5 (2.1, 3.6)	0.8 (0.6 to 1.1)	0.5 (0.4 to 0.7)	0.6 (0.4 to 0.9)	0.025
NLR	2.4 (1.9, 3.4)	2.5 (1.8, 3.7)	2.2 (1.7, 2.9)	2.6 (1.7, 3.5)	0.9 (0.8 to 1.0)	1.0 (0.8 to 1.1)	1.1 (0.9 to 1.3)	0.362
MPO, ng/mL	2.9 (1.9, 3.7)	2.8 (2.0, 3.9)	2.7 (1.5, 3.9)	1.9 (1.3, 3.0)	1.0 (0.8 to 1.2)	0.8 (0.7 to 0.9)	0.8 (0.6 to 1.0)	0.047
AZU1, pg/mL	1.8 (1.5, 2.9)	2.0 (1.5, 2.8)	1.5 (1.2, 2.2)	1.2 (1.0, 1.7)	0.9 (0.7 to 1.0)	0.6 (0.5 to 0.8)	0.7 (0.6 to 0.9)	0.019

Yu M, et al. Circulation. 2024 Sep 24;150(13):981-993.

Low-dose colchicine and high-sensitivity C-reactive protein after myocardial infarction: A combined analysis using individual patient data from the COLCOT and LoDoCo-MI studies

Pre-treatment and post-treatment hs-CRP for COLCOT and LoDoCo-MI

Characteristic	COLCOT				LoDoCo-MI			
	Overall, N = 207[a]	Placebo, N = 108[a]	Colchicine, N = 99[a]	p-value[b]	Overall, N = 222[a]	Placebo, N = 111[a]	Colchicine, N = 111[a]	p-value[b]
Pre-treatment hs-CRP, mg/L (continuous)				0.170				0.891
Mean (SD)	8.43 (12.09)	8.95 (11.28)	7.87 (12.95)		20.91 (38.20)	20.55 (37.79)	21.26 (38.77)	
Median (IQR)	4.28 (2.28, 8.78)	4.83 (2.47, 11.83)	4.00 (2.13, 6.98)		7.40 (3.00, 17.58)	7.70 (3.00, 18.90)	6.90 (3.10, 15.60)	
Absolute change				0.353				0.439
Mean (SD)	−5.99 (12.37)	−6.37 (11.22)	−5.57 (13.55)		−17.07 (37.82)	−16.47 (38.05)	−17.68 (37.75)	
Median (IQR)	−2.26 (−6.34, −0.80)	−2.67 (−9.42, −0.82)	−2.10 (−5.31, −0.80)		−4.00 (−13.93, −1.00)	−3.30 (−12.50, −0.90)	−4.30 (−13.75, −1.10)	
Range	−90.42, 31.69	−76.90, 13.72	−90.42, 31.69		−224.00, 33.50	−224.00, 20.30	−201.80, 33.50	
% change in hs-CRP (%, continuous)				0.640				0.088
Mean (SD)	−38.33 (123.30)	−45.00 (70.57)	−31.05 (162.54)		−38.61 (115.62)	−34.01 (132.07)	−43.20 (96.82)	
Median (IQR)	−65.94 (−81.75, −39.78)	−66.79 (−81.18, −34.88)	−64.76 (−83.17, −40.69)		−73.53 (−89.32, −35.70)	−64.29 (−87.61, −31.06)	−77.85 (−91.56, −46.91)	

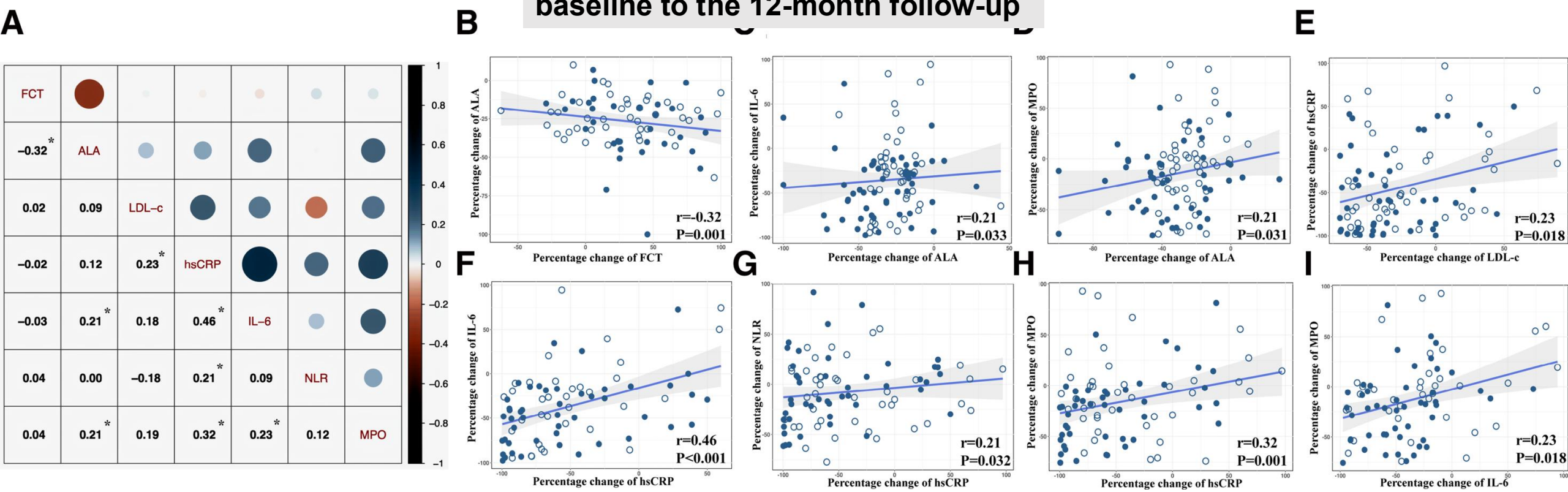
Colchicine was not significantly associated with post-treatment hs-CRP when it was considered as a continuous variable but was significantly associated with increased odds of achieving post-treatment hs-CRP values ≤1.0 mg/L compared to placebo (odds ratio: 1.64, 95% confidence interval: 1.07 to 2.51, P = 0.024).

Sun M, et al. Int J Cardiol. 2022 Sep 15;363:20-22.

Colchicine on Coronary Plaque Stability in Acute Coronary Syndrome

Optical Coherence Tomography - The COLOCT Randomized Clinical Trial

baseline to the 12-month follow-up



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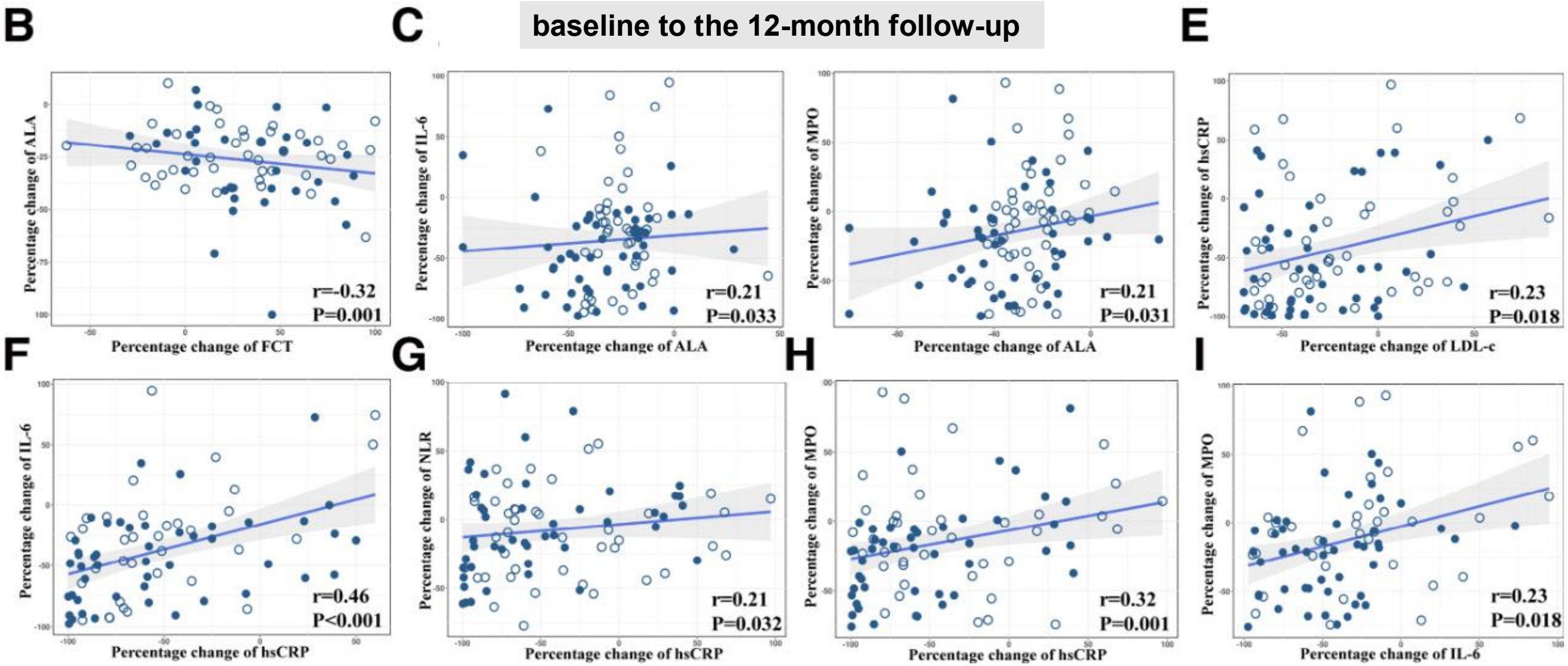

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Anti-Inflammatory Therapy Has Entered All Major Guidelines in the Americas and Europe

ESC European Society of Cardiology
European Heart Journal (2024) 45, 3415–3537
https://doi.org/10.1093/eurheartj/ehae177

ESC GUIDELINES

2024 ESC Guidelines for the management of chronic coronary syndromes

Recommendation Table 20 — Recommendations for anti-inflammatory drugs in patients with chronic coronary syndrome (see also Evidence Table 20)

Recommendation	Class[a]	Level[b]
In CCS patients with atherosclerotic CAD, low-dose colchicine (0.5 mg daily) should be considered to reduce myocardial infarction, stroke, and need for revascularization.[714–716]	IIa	A

CAD, coronary artery disease; CCS, chronic coronary syndrome.
[a]Class of recommendation.
[b]Level of evidence

CLINICAL PRACTICE GUIDELINE

2023 AHA/ACC/ACCP/ASPC/NLA/PCNA Guideline for the Management of Patients With Chronic Coronary Disease

"In patients with chronic coronary disease (CCD), the addition of colchicine for secondary prevention may be considered to reduce recurrent ASCVD events". (2B, B-R)

CLINICAL PRACTICE GUIDELINE

2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes

"In patients after ACS, low-dose colchicine may be reasonable to reduce risk of MACE". (2B, B-R)

Vrints C, et al. European Heart Journal (2024) 45, 3415–3537

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