### Ischemic Heart Disease Mgmt.

**Long-term Surveillance Plan Following First Episode of IHD**

- **Hx:** assess for barriers to therapy, modifiable risks, comorbidities
- **PE:** HF, arrhythmia, new/worsened bruit or murmur, abdo aorta status
- **Invest:** annual resting ECG, metabolic fitness (lipids, glucose, CBC, renal)
- **Refer:** consider cardiac care team (cardiologist, dietician, trainer as required)

**Key References:**

### Secondary Management of Ischemic Heart Disease

#### Therapy Guidance RRR

- **Cardiac Rehab** - home or hospital based programs shown to reduce infarction/ cardiovascular mortality at 1 year post MI 28%
- **Anti-Hypertensive** - target BP <140/90 10-30%
- **ASA** - 75-162 mg daily (use clopidogrel if intolerant) 10-15%
- **ACE-Inhibitor** - best evidence of benefit post-MI: ramipril, perindopril 20%
- **Statin** - titrate to max dose with:
  - rosuvastatin, atorvastatin, simvastatin 10-30%
  - monitor for hepatotoxicity (ALT), myopathy (CK)
- **β-blocker** - strongest evidence of benefit post-MI:
  - metoprolol, carvedilol, bisoprolol 25%
  - if intolerant or contraindicated, and experiencing angina, substitute with CCB = long acting nitrates
  - start at low dose and titrate upwards

### Patient Context Guidance on Management

- **Sev. Hepatic Dz** → reduce dose of metoprolol, carvedilol, some statins
- **CKD / CRF** → reduce dose of ACE-I, B-blockers, diuretics if GFR <50
- **COPD** → use ultra - cardioselective B-blocker (bisoprolol)
- **Hx of PCI + stent** → add P2Y12 Inhibitor (clopidogrel) for 12 months
- **Diabetes** → ensure good control, lifestyle; see Type 2 Diabetes card
- **Worsening angina** → arrange for urgent/emergent cardiac care

### NYHA Classes of Functional Capacity

- **I** - no limitation of physical activity
- **II** - ordinary activity results in dyspnea, palpitations, fatigue. Relieved by rest
- **III** - less than ordinary activity results in dyspnea, palpitations. Relieved by rest
- **IV** - physical activity not tolerated. Dyspnea, palpitations may be present at rest

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- Fix: assess for barriers to therapy, modifiable risks, comorbidities
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- Invest: annual resting ECG, metabolic fitness (lipids, glucose, CBC, renal)
- Refer: consider cardiac care team (cardiologist, dietician, trainer as required)