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Khattab Y
Keegan DA

# Ischemic Heart Disease Mgmt.

| | Modifiable Risks | IHD RR* |
|---|---|---|
| Pro-tective | - Exercise (aerobic, moderate intensity, 3-4x per week) | 0.58 |
| | - Mediterranean diet (olive oil, vegetables, grains, nuts, fish) | 0.60 |
| | - Light to moderate EtOH (<30g per day) | 0.70 |
| Threatening | - Periodontal disease | 1.20 |
| | - Elevated childhood BMI | 1.22 |
| | - Disturbed, short sleep (<6 hours) | 1.55 |
| | - Depression | 1.60 |
| | - Smoking (20 cigarettes per day) | 1.78 |
| | - Waist circumference: Men > 101.6 cm, Women > 89 cm | 2.00 |

*RR = Relative Risk

## Secondary Management of Ischemic Heart Disease

| | Therapy | Guidance | RRR |
|---|---|---|---|
| Long - Term Therapy | 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<br>- ***see Hypertension cards for details*** | 10-30% |
| | ASA | - 75- 162 mg daily (use clopidogrel if intolerant) | 10-15% |
| | ACE- Inhibitor | - best evidence of benefit post-MI: ramipril, perindopril<br>- if intolerant or contraindicated substitute with ARB<br>- do not combine with ARB<br>- stop if hyperkalemic or rise in Cr >30% above baseline | 20% |
| | Statin | - titrate to max dose with:<br>-rosuvastatin, atorvastatin, simvastatin<br>- titrate to moderate dose if risk for statin assoc events<br>-monitor for hepatotoxicity (ALT), myopathy (CK)<br>- if intolerant consider substituting with niacin | 10-30% |
| 3 mo ( for life if LV dysfxn., HF) | ß- blocker | - strongest evidence of benefit post - MI:<br>-metoprolol, carvedilol, bisoprolol<br>- if intolerant or contraindicated, and experiencing angina, substitute with CCB + long acting nitrates<br>- start at low dose and titrate upwards | 25% |

| Patient Context | Guidance on Management |
|---|---|
| - Sev. Hepatic Dz | → reduce dose of metroprolol, 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

## 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:** Mancini GB, et al. Canadian Cardiovascular Society Guidelines for the Diagnosis and Management of Stable Ischemic Heart Disease. CJC. 2014 May; 30 (8): 837-49) McAlister F, et al. Randomised trials of secondary prevention programmes in coronary heart disease: systematic review. BMJ. 2001 August; 323: 957. Neal B, et al. Effects of ACE inhibitors, calcium antagonists, and other blood-pressure-lowering drugs: results of prospectively designed overviews of randomised trials. Lancet. 2000 Dec; 356 (9246): 1955-64.