Management of Stable Ischemic Heart Disease: Recommendations from the ACP

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The American College of Physicians (ACP), in collaboration with the American College of Cardiology Foundation, American Heart Association, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, and Society of Thoracic Surgeons, has developed a guideline on the management of stable ischemic heart disease (IHD). This summary presents recommendations related to risk factor modification (including strategies of unproven benefit), medical therapies to prevent myocardial infarction and death and to relieve symptoms, and alternative therapies for relief of symptoms in patients with stable IHD. The full guideline contains additional recommendations related to patient education, revascularization to improve survival and symptoms, and patient follow-up.

Risk Factor Modification

LIPID MANAGEMENT

Lifestyle modifications are recommended for lipid management in all patients, including daily physical activity and weight management. The recommended dietary therapy for all patients should include reducing intake of saturated fats to less than 7% of total calories, reducing intake of trans-fatty acids to less than 1% of total calories, and reducing daily cholesterol intake to less than 200 mg. In addition, moderate- to high-dose statin therapy should be prescribed in the absence of contraindications or documented adverse effects.

HYPERTENSION

Patients who have hypertension should receive counseling on the need for lifestyle modification. This includes maintaining a healthy weight, increasing physical activity, limiting intake of dietary sodium, moderating alcohol consumption, and increasing intake of fresh fruits, vegetables, and low-fat dairy products.

In addition to following a trial of lifestyle modifications, patients with stable IHD and a blood pressure of 140/90 mm Hg or higher should be treated with antihypertensive drug therapy to achieve goal blood pressure. Specific medications should be based on individual patient characteristics, and may include angiotensin-converting enzyme inhibitors and/or beta blockers, with other drugs such as thiazide diuretics or calcium channel blockers, if needed.

DIABETES MELLITUS

Rosiglitazone (Avandia) should not be initiated in patients with diabetes mellitus who have stable IHD.

PHYSICAL ACTIVITY

Risk assessment with a physical activity history is recommended to guide prognosis and prescription for all patients. When clinically indicated, an exercise test should be performed. Based on the results of this assessment, patients should be encouraged to engage in 30 to 60 minutes of moderate-intensity aerobic activity at least five days per week, and preferably seven days per week. Aerobic activity should be supplemented by an increase in daily activities, such as walking during breaks at work, gardening, or ▶

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household activities, to improve cardiorespiratory fitness and motivate patients who are less fit, less active, and at increased risk. For patients considered at-risk at first diagnosis, medically supervised programs such as cardiac rehabilitation and physician-directed, home-based programs are recommended.

WEIGHT MANAGEMENT

Patient body mass index or waist circumference should be assessed at every visit. Physicians should consistently encourage patients to maintain or reduce weight through an appropriate balance of lifestyle physical activity, structured exercise, caloric intake, and formal behavioral programs when indicated to help patients maintain or achieve a body mass index between 18.5 and 24.9 kg per m^2, and a waist circumference less than 40 inches (102 cm) in men and less than 35 inches (89 cm) in women (less for certain racial groups). The initial goal of weight loss therapy should be to reduce body weight by approximately 5% to 10% from baseline; if successful, further weight loss can be attempted if indicated.

SMOKING CESSATION

Cessation of smoking, and avoidance of exposure to environmental tobacco smoke at work and at home, should be encouraged for all patients. A five-step strategy for smoking cessation called the 5 A's framework (ask, advise, assess, assist, arrange), patient follow-up, referral to special programs, and pharmacotherapy are also recommended.

REDUCTION STRATEGIES OF UNPROVEN BENEFIT

Estrogen therapy should not be initiated in postmenopausal women with stable IHD for reducing cardiovascular risk or improving clinical outcomes.

Elevated homocysteine levels should not be treated with folate or vitamins B_6 and B_{12} to reduce cardiovascular risk or improve clinical outcomes. In addition, chelation therapy should not be used to improve symptoms or reduce cardiovascular risk.

The following therapies should not be used to reduce cardiovascular risk or improve clinical outcomes: vitamin C, vitamin E, and beta carotene supplementation; garlic; coenzyme Q10; selenium; and chromium.

Medical Therapy to Prevent Myocardial Infarction and Death

Aspirin (75 to 162 mg daily) should be continued indefinitely in the absence of contraindications. When aspirin is contraindicated, treatment with clopidogrel (Plavix) is a reasonable option. Dipyridamole (Persantine) should not be used as antiplatelet therapy.

In all patients with normal left ventricular function following myocardial infarction or acute coronary syndromes, beta-blocker therapy should be initiated and continued for three years. For all patients with systolic left ventricular dysfunction (ejection fraction 40% or less) with heart failure or previous myocardial infarction, metoprolol succinate (Toprol XL), carvedilol (Coreg), or bisoprolol (Zebeta) should be used, unless contraindicated.

In all patients with stable IHD who also have hypertension, diabetes, left ventricular systolic dysfunction, or chronic kidney disease, angiotensin-converting enzyme inhibitors should be prescribed, unless contraindicated. Angiotensin receptor blockers are recommended for patients who have indications for, but are intolerant of, angiotensin-converting enzyme inhibitors.

Annual influenza vaccination is recommended for patients with stable IHD.

Medical Therapy for Symptom Relief

Beta blockers should be prescribed as initial therapy for relief of symptoms. When beta blockers are contraindicated or cause unacceptable adverse effects, calcium channel blockers or long-acting nitrates should be prescribed. If initial beta-blocker therapy is unsuccessful, calcium channel blockers or long-acting nitrates should be prescribed in combination with beta blockers.

Sublingual nitroglycerin or nitroglycerin spray should be used for immediate relief of angina in patients with stable IHD.

Alternative Therapies for Symptom Relief

Acupuncture should not be used to improve symptoms or reduce cardiovascular risk.

MICHAEL DEVITT, *AFP* Associate Editor ■