**Beta-Blockers**

Indicated in post-MI, unstable angina, and non-ST segment MI. Prescribe to all patients without a contraindication to beta-blocker therapy, except low risk patients (i.e., those without previous infarction, anterior infarction, advanced age or complex ventricular ectopy). Treatment should begin within a few days of the event and continued indefinitely.

**Contraindications:**
- Cardiogenic shock
- Sick sinus syndrome
- History of asthma/severe COPD
- Hypersensitivity to beta-blockers
- HR <50 bpm
- P-R interval >.24 seconds
- Second or third degree AV block

**Precautions and Close Monitoring:**
- Diabetes Mellitus
- Severe LV dysfunction with CHF
- SBP <100 mmHg
- HR <60 bpm
- Peripheral vascular disease
- Peripheral hypoperfusion

Patients receiving beta-blockers should be advised:
- Side effects may occur during initiation of therapy but do not prevent long term use
- Use is intended as long term therapy
- Abrupt discontinuation should be avoided
- Self monitor for evidence of hypotension and bradycardia

**Nitrates**

Indicated in treatment and prophylaxis of angina. Patients should be given oral, sublingual or spray NTG and instructed in its use.

**Contraindications:**
Concomitant phosphodiesterase type 5 inhibitors such as Viagra

**Calcium Channel Blockers**

For ischemic symptoms when beta-blockers are not successful or contraindicated. Short acting dihydropyridine antagonists (e.g., nifedipine) should be avoided.
### Antiplatelet Drugs

**Aspirin**
- Indicated in post-MI, unstable angina, non-ST segment MI.
- Prescribe 75 to 325 mg/d in the absence of contraindications.
- **Relative Contraindications:**
  - Blood dyscrasias
  - Severe hepatic disease
  - Active GI Bleeding
- **Absolute Contraindications:**
  - Hypersensitivity to salicylates

**Prescribe Clopidogrel 75 mg daily when aspirin is not tolerated due to hypersensitivity or gastrointestinal intolerance.**

The combination of aspirin and clopidogrel for 9 months after unstable angina/NSTEMI.

### Anticoagulation Therapy

Consider long-term anticoagulation post-MI for the following patients:
- Post-MI patients who are unable to take aspirin daily* or other antiplatelet agents
- Post-MI patients with persistent atrial fibrillation
- Post-MI patients with left ventricular thrombus

*If patient is receiving antiplatelet therapy, specific formulas contain antithrombin properties that may preclude further anticoagulation requirements.

### Digoxin

Indicated in patients with heart failure due to left ventricular systolic dysfunction (EF <35-40%) who are not adequately responsive to ACE inhibitors and diuretics and in patients with atrial fibrillation or who require additional rate control.

**Precautions and Close Monitoring:**
- Elderly patients
- Patients with impaired renal function
**ACE Inhibitors**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Indicated in post-MI stable high-risk patients (elderly, anterior infarction, previous infarction), CHF, LV dysfunction (EF &lt;40%), hypertension, or diabetes unless contraindicated. **</td>
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<tr>
<td></td>
<td>Continue indefinitely for all patients with left ventricular systolic dysfunction (EF ≤40%) or symptoms of heart failure. Use as needed to manage blood pressure or symptoms in all other patients.</td>
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<tr>
<td></td>
<td><strong>Contraindications:</strong></td>
</tr>
<tr>
<td></td>
<td>• History of intolerance or adverse reaction to ACE inhibitors</td>
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<tr>
<td></td>
<td>• Elevated levels of serum potassium (K+ &gt;5.5 mEq/L)</td>
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<td></td>
<td>• Renal artery stenosis</td>
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<td>• Symptomatic hypotension</td>
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<td>• Shock</td>
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<td>• Pregnancy</td>
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<td></td>
<td><strong>Precautions and Close Monitoring:</strong></td>
</tr>
<tr>
<td></td>
<td>• SBP &lt;90 mmHg</td>
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<tr>
<td></td>
<td>• Elevated levels of serum creatinine (Scr &gt;3) or creatinine clearance &lt;30 ml/min</td>
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<td><strong>Consider angiotensin receptor blockers (ARBs) in patients with intolerance to ACE inhibitor therapy.</strong></td>
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<td><strong>Refer to PHP Diabetic Clinical Practice Guideline.</strong></td>
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</table>

**Cholesterol-Lowering Agents**

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<td>Advise all patients with CAD to follow the AHA Step II diet.</td>
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<tr>
<td></td>
<td>Patients with LDL levels &gt; 125 mg/dL despite the AHA Step II diet should be placed on drug therapy with the goal of reducing LDL to &lt;100 mg/dL.</td>
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<td></td>
<td>Patients with normal plasma cholesterol levels who have a HDL cholesterol level of &lt;35 mg/dL should receive therapy designed to elevate the HDL level, such as increased physical activity.</td>
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<tr>
<td>CATEGORY</td>
<td>RECOMMENDATIONS</td>
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<tr>
<td>Ventricular Function</td>
<td>Assess LVEF in acute coronary syndrome and coronary disease patients during hospital or outpatient evaluation, if appropriate.</td>
</tr>
<tr>
<td>Stress Test With or Without Imaging</td>
<td>Perform a stress test with or without imaging in appropriate patients (i.e., adult patients with an intermediate pretest probability of CAD based on gender, age, and symptoms, undergoing initial evaluation with known CAD, before discharge for prognostic assessment, activity prescription, or evaluation of medical therapy, before and after revascularization), timing to be determined by practitioner.</td>
</tr>
<tr>
<td>Lipid Profile</td>
<td>Perform cholesterol profile at 4-6 weeks following AMI and repeat 3 months following initiation of therapeutic lifestyle changes (TLC) and/or drug management to determine adherence and response to therapy.</td>
</tr>
</tbody>
</table>

Test in fasting state and include:
- Total Cholesterol
- Triglycerides
- LDL
- HDL

Target Values:
- Cholesterol <200 mg/dL
- Triglycerides <150 mg/dL
- LDL <100 mg/dL
- HDL >40 mg/dL

Category of CAD risk based on lipoprotein levels in adults:
- High: LDL >130 mg/dL, HDL <40 mg/dL, Triglycerides >200 mg/dL
- Borderline: LDL 100-129 mg/dL, HDL 40-59 mg/dL, Triglycerides 150-199 mg/dL
- Low: LDL <100 mg/dL, HDL >60 mg/dL, Triglycerides <150 mg/dL

Once cholesterol goal has been achieved, measure lipid profile at least every 4 to 6 months to monitor response and adherence to drug therapy for one year. Long-term monitoring entails annual lipoprotein analyses.

Consider more aggressive targets for HDL cholesterol and triglycerides in women.
### PSYCHOLOGY ASSESSMENT

| Depression Screen | Routine screening for adults. **

** Refer to PHP Preventive Health Recommendations. |

### EDUCATION AND COUNSELING

| Smoking Cessation | Assessment of smoking status at each visit.

All smokers should be counseled on tobacco cessation at each visit. Refer to stop smoking program and if necessary, recommend smoking cessation aids. Follow up on progress at each visit. |

| Education and Self-Management Principles |

This includes:

- Nutrition Counseling
- Weight Management
- Exercise/Physical Activity

Advise all patients with CAD about symptoms of AMI and instruct how to seek help if symptoms occur.

Advise patient and family on lower sodium, lower fat, lower cholesterol and higher fiber diet.

Recommend AHA Step II diet, which is low in saturated fat and cholesterol (<7% of total calories as saturated fat and <200 mg/d cholesterol).

Advise patient to achieve or maintain healthy weight (BMI of 25.0-30.0 is considered overweight, BMI >30.0 is considered obese).

Advise patients on the appropriate type, level of intensity, and frequency of a regular exercise/physical activity program (e.g., walking, housework, climbing stairs). For certain patients a referral to a monitored exercise program may be appropriate.

Advise patient when to return to previous levels of activity, sexual activity, driving, and employment.
### EDUCATION AND COUNSELING

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<td><strong>Blood Pressure Control</strong></td>
<td>Monitor BP every office visit.</td>
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<td>Target adults: goal is &lt;140/90 mmHg. Preferred goal is &lt; 130/85 mmHg.</td>
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</tbody>
</table>
| **Glycemic Control**                 | For patients who are diabetics, quarterly testing is recommended if poorly controlled or if therapy has changed. **  
                                      | Target HbA1c <7.0%.                                                                                 |
|                                      | ** Refer to PHP Diabetes Clinical Practice Guideline.                                             |
| **Cardiac Rehabilitation**           | Consider cardiac rehabilitation** or a monitored exercise program for those patients who may be at higher risk for infarction or sudden death.  
                                      | **Refer to Medical Management Guideline: Cardiac Rehabilitation – Commercial or Secure Horizons    |

As a guideline, this document is intended to provide information to aid health care providers and is not a substitute for clinical judgement in treating individual patients. It is subject to updates pending the release and review of additional data, based upon changes in scientific knowledge and technology. Approved by the Medical Management Guideline Committee in December 2003.
References:


