



Stable Coronary Artery Disease Clinical Guideline

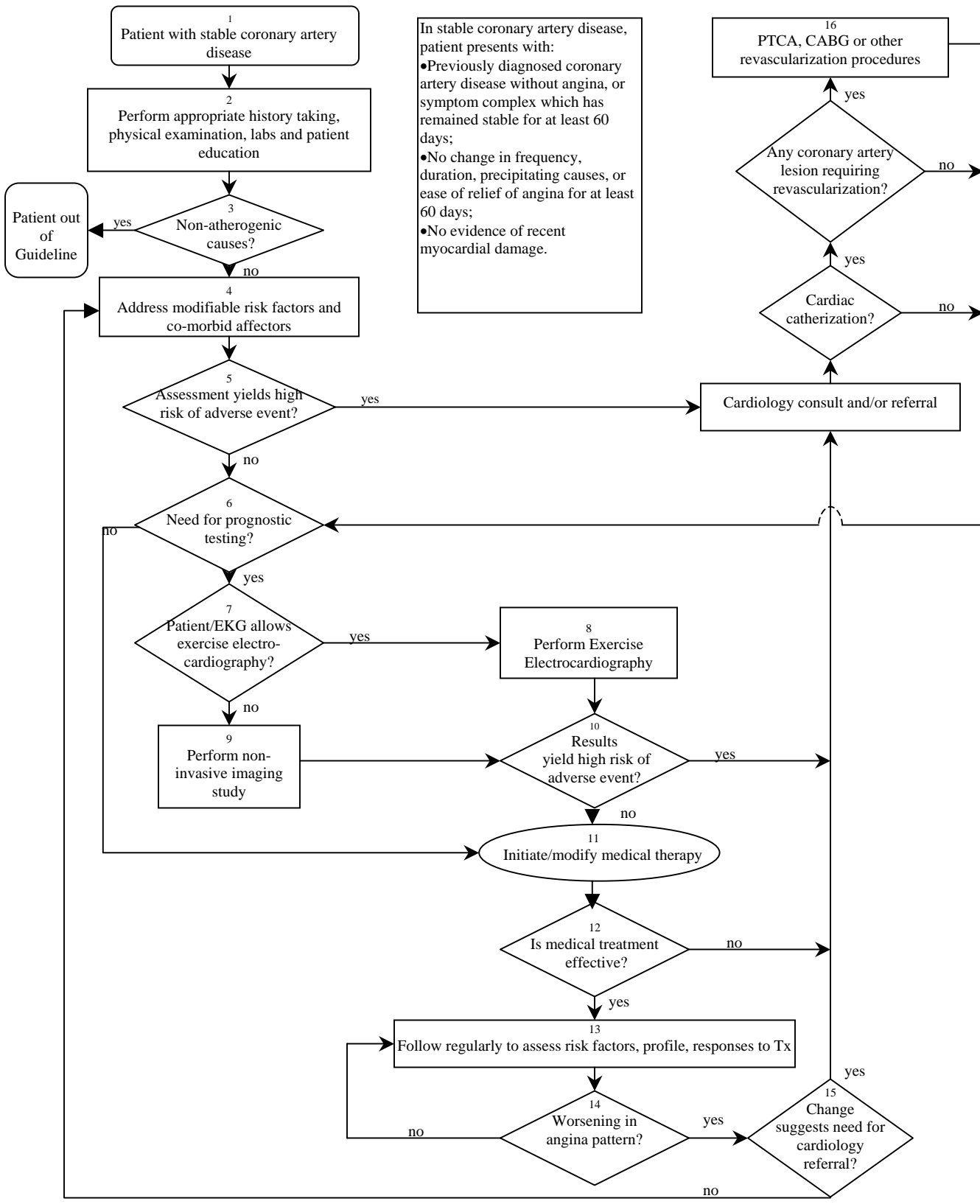
Guideline History

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These Guidelines are promulgated by Sentara Healthcare (SHC) as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these Guidelines. The SHC Guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment.

Stable Coronary Artery Disease

Source: Institute for Clinical Systems Improvement 2007 and SHM Physician Advisory Council



In stable coronary artery disease, patient presents with:

- Previously diagnosed coronary artery disease without angina, or symptom complex which has remained stable for at least 60 days;
- No change in frequency, duration, precipitating causes, or ease of relief of angina for at least 60 days;
- No evidence of recent myocardial damage.

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Stable Coronary Artery Disease Annotations

1. Patient with Stable Coronary Artery Disease

This guideline applies to patients with coronary artery disease with or without angina. Examples include patients with prior myocardial infarctions, prior revascularization (i.e., PTCA, CABG), angiographically proven coronary atherosclerosis, or reliable noninvasive evidence of myocardial ischemia.

2. Perform Appropriate History Taking, Physical Examination, Laboratory Studies and Patient Education

Important points to elicit on history taking are:

- Recognition that women may have atypical symptoms of cardiac ischemia. (These may include fatigue, SOB, without chest pain, nausea and vomiting, back pain, jaw pain, dizziness and weakness.)
- History of previous heart disease
- Possible nonatheromatous causes of angina pectoris (e.g., aortic stenosis, hypertrophic cardiomyopathy)
- Comorbid conditions affecting progression of CAD
- Symptoms of systemic atherosclerosis (i.e., claudication, TIAs and bruits)
- Severity and pattern of symptoms of angina pectoris

3. Non-Atherogenic Causes?

Aortic stenosis is an important nonatherogenic cause of angina.

4. Address Modifiable Risk Factors and Co-Morbid Affectors

Comorbid conditions that could affect myocardial ischemia may include hypertension, anemia, thyroid disease, hypoxemia, and others. Modifiable risk factors for coronary heart disease need to be evaluated and may include smoking, inadequate physical activity, stress, dyslipidemia, hyperlipidemia, obesity, hypertension, and diabetes mellitus.

5. Assessment Yields High Risk of Adverse Event?

Some patients are considered to be at high risk for infarction or death on the basis of history, physical examination and initial laboratory findings. Patients presenting with accelerating symptoms of angina, symptoms of peripheral vascular disease, or symptoms of left ventricular dysfunction should be referred to a cardiologist unless precluded by other medical conditions.

6. Need for Prognostic Testing?

Prognostic testing is appropriate for patients in whom risk determination remains unclear after the evaluations have been completed, or in whom cardiac catheterization is deemed inappropriate by the cardiologist. Prognostic testing, may precede or follow an initial course of pharmacological therapy.

7. Patient /EKG Allows Exercise Electrocardiography?

Sensitivity or exercise electrocardiography may be reduced for patients unable to reach the level of exercise required for near maximal effort, such as:

- Patients taking beta blockers
- Patients in who fatigue, dyspnea, or claudication symptoms develop
- Patients with vascular, orthopedic, or neurological conditions who cannot perform leg exercises
- Reduced specificity may be seen in patients with abnormalities on baseline EKG, such as those taking digitalis medications, and in patients with left ventricular hypertrophy or left bundle branch block.

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8. Perform Exercise Electrocardiography

Most patients with normal resting EKG's, who can exercise, and are not taking digoxin, can undergo standard treadmill exercise testing.

9. Perform Non-Invasive Imaging Study

A noninvasive imaging study such as myocardial perfusion scintigraphy or stress echocardiography should best meet the patient's needs while providing the most clinical usefulness and cost-effectiveness within the provider's institution. An imaging study should be selected through discussion with the cardiologist or imaging expert.

10. Results Yield High Risk of Adverse Event?

Exercise electrocardiography and prognostic imaging studies may yield results that indicate high, intermediate or indeterminate or low risk of adverse clinical events. High-risk patients should have a cardiology consultation unless they are not considered to be potential candidates for revascularization. Patients who are at intermediate or indeterminate risk may benefit from cardiology consultation and/or further noninvasive imaging if an exercise electrocardiogram has been performed. Low risk patients can generally be managed medically, with a good prognosis. Low risk patients may benefit from angiography if the diagnosis remains unclear; however, angiography is unlikely to alter outcome in these patients.

11. Patient Education and Review Principles of Medication Therapy

12. Is Medical Treatment Effective?

Effectiveness of pharmacologic treatment is measured by whether the anginal pain is controlled within the definition of stable coronary artery disease.

13. Follow Regularly to Assess Risk Factors, Profile, Responses to Treatment

There is no consensus in the literature regarding frequency of follow-up; ongoing management needs and follow-up should be individualized.

14. Worsening in Angina Pattern?

A new occurrence of angina or a worsening in the chronic stable angina pattern is considered to be present when any of the following occur:

- The symptom complex becomes less stable.
- There is change in frequency, duration, precipitating causes, or ease in relief of angina.
- There is evidence of recent myocardial damage.

15. Change Suggests Need for Cardiology Referral?

When such change is no longer managed by alterations in the pharmacologic therapy prescribed, cardiology consultation or referral for possible invasion intervention may be appropriate.

16. Percutaneous Transluminal Coronary Angioplasty (PTCA), Coronary Artery Bypass Graft (CABG) or Other Revascularization Procedures

The relative benefits of revascularization compared with medical therapy are enhanced by an increase in absolute number of severely narrowed coronary arteries, the degree of left ventricular systolic dysfunction and the magnitude of myocardial ischemia. Among patients with lesser disease, PTCA and CABG have not been shown to reduce mortality or the risk of myocardial infarction, but do reduce the symptoms of angina and the intensity of antianginal therapy, as well as increase exercise capacity.

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