Sidebar A: SIGNS AND SYMPTOMS OF CORONARY ARTERY DISEASE (CAD)

• Prior myocardial infarction (MI) and/or pathologic Q-waves on the resting electrocardiogram (ECG)
• Typical stable angina in males age >50 or females age >60
• Cardiac stress test showing evidence of myocardial ischemia
• Left ventricular (LV) segmental wall motion abnormality by angiography or cardiac ultrasound
• Silent ischemia, defined as reversible ST-segment depression by ambulatory ECG monitoring
• Significant obstructive CAD by angiography
• Prior coronary revascularization (percutaneous coronary intervention or coronary artery bypass graft surgery)

Sidebar E: Recommended Medications for Patients with IHD

Aspirin (or clopidogrel) reduces cardiovascular (CV) events in patients with acute MI, previous MI, and unstable angina
Aspirin reduces risk of MI in patients with chronic stable angina
Beta-blockers improve symptoms in patients with IHD
Beta blockers improve CV outcomes in patients with IHD, previous MI and ischemic LV dysfunction
Beta-blockers reduce CV events in patients with silent ischemia
Nitroglycerin (prn)
ACE inhibitors improve CV outcomes in patients with IHD, and are especially recommended in patients with diabetes or low LV ejection fraction
Lipid-lowering therapy improves CV outcomes in patients with IHD and elevated lipids
Lipid-lowering therapy improves CV outcomes in patients with IHD and average cholesterol
Gemfibrozil improves outcomes in patients with IHD and low high-density lipoproteins – cholesterol (HDL-C)

Follow-Up and Prevention:
A = Aspirin and Anti-anginal therapy
B = Beta-blocker and Blood pressure
C = Cigarette smoking and Cholesterol
D = Diet and Diabetes
E = Education and Exercise

Sidebar F: Patient Education

• Assess the patient’s baseline understanding
• Elicit the patient’s desire for information
• Use epidemiologic and clinical evidence
• Use ancillary personnel and professional patient educators when appropriate
• Develop a plan with the patient on what to do when symptoms occur
• Involve family members in educational efforts
• Remind, repeat and reinforce

FOR FURTHER MEDICATION INFORMATION SEE DOCUMENT, PHARMACOTHERAPY FOR CARDIOVASCULAR DISEASES IN PRIMARY CARE POCKET GUIDE

VA/DoD Clinical Practice Guideline Management of Ischemic Heart Disease (IHD)
Module G Pocket Guide
Follow-Up & Secondary Prevention

1. Patient with known ischemic heart disease [A]
2. Obtain focused history, physical exam, and review of medication and reversible risk factors [B]
3. Are there acute symptoms, changes in symptoms or inadequately controlled symptoms? [C]
4. GO TO CORE MODULE (Assess for Acute Coronary Syndromes or Stable Angina)
5. Are there indications for assessment of LV function (e.g., or symptoms of CHF)? [D]
6. Assess left ventricular function [E]
7. Use Module F
8. If LVEF < 0.40 ensure pharmacotherapy for CHF/LV dysfunction
   See Chronic Heart Failure guideline
9. Indications for non-invasive cardiac stress test? [H]
10. Consider cardiac stress test Use Module F
11. Referring Cardiology for possible angiography if test results indicate diagnosis of CAD with high/intermediate features, or indeterminate
12. Refer to Cardiology for evaluation and/or revascularization
13. Is patient at high risk for sudden cardiac death [K]
14. or Other indicator for referral to Cardiology? [J]
15. Continue on next side
IHD patient with optimally controlled ischemic symptoms or no symptoms, with or without prior event

Continue aspirin and beta-adrenergic blocking agent

Does patient have LDL-C ≥ 100 mg/dL or HDL < 40 mg/dL or elevated TG?

Control hypertension

Does patient have LDL-C ≥ 100 mg/dL or HDL < 40 mg/dL or elevated TG?

Initiate therapy to address lipid abnormalities

See Dyslipidemia guideline

Does patient have LDL-C ≥ 100 mg/dL or HDL < 40 mg/dL or elevated TG?

Initiate therapy to address lipid abnormalities

See Dyslipidemia guideline

Does patient have LDL-C ≥ 100 mg/dL or HDL < 40 mg/dL or elevated TG?

Initiate therapy to address lipid abnormalities

See Dyslipidemia guideline

Initiate tobacco use cessation

Manage diabetes

Manage diabetes

Manage diabetes

Manage depression

Provide patient and family education

Consider exercise rehabilitation program

Schedule regular follow-up

Sidebar B: Symptom Assessment

Symptoms that May Represent Ischemia or MI

- Chest pain, discomfort, pressure, tightness, or heaviness (defined as at least a one-class increase Canadian Cardiovascular Society classification)
- Radiating pain to the neck, jaw, arms, shoulders, or upper back
- Unexplained or persistent shortness of breath
- Unexplained epigastric pain
- Unexplained indigestion, nausea, or vomiting
- Unexplained diaphoresis
- Unexplained weakness, dizziness, or loss of consciousness

Symptom Characteristics that Suggest Noncardiac Pain*

- Pleuritic pain (i.e., sharp or knife-like pain brought on by respiratory movements or cough)
- Primary or sole location of discomfort in the middle or lower abdominal regions
- Pain that may be localized at the tip of one finger, particularly over costochondral junctions or the LV apex
- Pain reproduced with movement or palpation of the chest wall or arms
- Constant pain that lasts for many hours
- Very brief episodes of pain that last a few seconds or less
- Pain that radiates into the lower extremities

* Does not exclude the diagnosis of CAD

Sidebar C: Indications for Assessment of Left Ventricular Function

Symptoms of Congestive Heart Failure (CHF) (e.g., orthopnea or paroxysmal nocturnal dyspnea)

Significant impairments or recent decrement in exercise tolerance, due to dyspnea or fatigue

Physical signs of CHF (e.g., elevated jugular venous pressure, unexplained pulmonary rales, laterally displaced point of maximal impulse, and S3 gallop)

Cardiomegaly on chest x-ray

Prior MI

Sidebar D: Referral to Cardiology

Class 3-4 symptoms of ischemia or heart failure on medical therapy

Recurrent symptoms following recent (<6 mo) revascularization

High-risk findings on noninvasive testing

Noninvasive test results that are inadequate for management

Increased risk for sudden cardiac death

- History of sudden cardiac death
- History of sustained monomorphic ventricular tachycardia
- Reduced LVF (EF<0.40) and nonsustained ventricular tachycardia
- Reduced LVF (EF<0.40) and syncope of undetermined etiology
- Reduced LVF (EF <0.30) and prior history of MI