

REDUCING RISK IN HEART DISEASE THROUGH GENERAL PRACTICE¹⁻³

A summary Guide for preventing cardiovascular events in people with coronary heart disease

KEY POINTS

- Individualise treatments according to patients' co-morbidities, drug tolerance, lifestyle/living circumstances and wishes
- Any improvement in risk factors and movement towards the ideal goals and targets will be beneficial

Lifestyle/behavioural risk factors and management									
Smoking	<p>Goal: Complete cessation and avoidance of passive smoking</p> <ul style="list-style-type: none"> • Refer to Quitline 131 848. • Consider pharmacotherapy for patients smoking > 10 cigarettes per day. 								
Nutrition	<p>Goal: Establishment/maintenance of healthy eating patterns, with saturated & trans fatty acid intake ≤8% of total energy intake</p> <ul style="list-style-type: none"> • See Heart Foundation 'Enjoy Healthy Eating Messages' on back cover of full Guide.¹ 								
Alcohol	<p>Goal: Low risk alcohol consumption in those who drink</p> <ul style="list-style-type: none"> • Advise hypertensive patients to limit their intake of alcohol to two standard drinks per day if male, or one standard drink per day if female. By reducing alcohol consumption, blood pressure can fall substantially in some patients. 								
Physical Activity	<p>Goal: At least 30 minutes of moderate intensity physical activity on five or more days per week (150 mins per week minimum)</p> <ul style="list-style-type: none"> • Begin at low intensity and gradually increase over several weeks, particularly in the post-acute event period. 								
Weight Management	<p>Goal: Waist measurement < 94 cm (males) or < 80 cm (females); BMI < 25 kg/m²*</p> <ul style="list-style-type: none"> • Set intermediate achievable goals. <p>*Guidelines based on studies of European populations & may not be appropriate for all ages and ethnic groups</p>								
Biomedical risk factors and medical management									
Lipids	<p>Goal: TC < 4.0 mmol/L, LDL-C < 2.5 mmol/L; HDL-C > 1.0 mmol/L; Triglycerides < 2.0 mmol/L</p> <ul style="list-style-type: none"> • All patients should receive healthy eating advice. • Statin therapy is recommended for patients with CHD unless contraindicated. 								
Blood Pressure	<p>Goal: dependent on age and presence of diabetes; proteinuria; renal insufficiency:</p> <table border="0"> <tr> <td>Adults > 65 with no diabetes/no renal insufficiency</td> <td><140/90 mm Hg</td> </tr> <tr> <td>Adults <65; and all adults with diabetes or renal insufficiency</td> <td><130/85</td> </tr> <tr> <td>Adults with proteinuria 0.25-1g/day</td> <td><130/80</td> </tr> <tr> <td>Adults with proteinuria > 1 g/day</td> <td><125/75</td> </tr> </table> <ul style="list-style-type: none"> • Generally ACEi are recommended as first line antihypertensives in patients with CVD. 	Adults > 65 with no diabetes/no renal insufficiency	<140/90 mm Hg	Adults <65; and all adults with diabetes or renal insufficiency	<130/85	Adults with proteinuria 0.25-1g/day	<130/80	Adults with proteinuria > 1 g/day	<125/75
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Diabetes	<p>Goal: Identify undiagnosed type 2 diabetes; optimise BSL in those with diabetes (HbA1c ≤ 7%)</p> <ul style="list-style-type: none"> • Screen all with CHD for diabetes. • Manage hyperglycaemia with lifestyle interventions and pharmacotherapy if indicated. 								
Pharmacological management									
Antiplatelet Agents	<ul style="list-style-type: none"> • Use aspirin 70-150mg/day for all unless contraindicated. • Additional role for Clopidogrel in patients with recurrent cardiac or cerebral events; stent implantation. 								
ACE inhibitors (ACEi)	<ul style="list-style-type: none"> • For all patients post-MI and high-risk; initiate early unless contraindicated. • Use Angiotension II receptor antagonists for patients who develop unacceptable side effects on ACEis. 								
Beta-Blockers	<ul style="list-style-type: none"> • For most patients post acute coronary syndrome, unless contraindicated, and continued indefinitely. Carvedilol, bisoprolol and metoprolol (extended release) have been shown to provide additional survival benefits to patients with mild to moderate chronic heart failure already receiving background ACEi therapy. 								
Statins	<ul style="list-style-type: none"> • For all patients with CHD unless contraindicated. • In hospitalised patients should be commenced during that admission. 								
Anticoagulants	<ul style="list-style-type: none"> • Use warfarin in patients at high risk of thromboembolism post-MI. • Warfarin may sometimes be combined with aspirin -monitor closely for signs of bleeding. 								
Non-pharmacological management									
2 ^o prevention & cardiac rehabilitation programs	<ul style="list-style-type: none"> • All patients to have access to and be actively referred to a comprehensive secondary prevention/cardiac rehabilitation service. 								
Chest pain action plan	<ul style="list-style-type: none"> • All patients to have written action plan to follow in event of chest pain, including advice on use of antianginal medication and emergency action (Dial 000 for ambulance) if chest pain/discomfort is not completely relieved in 10-15 minutes. 								
Psychological and social management									
Psychological Management	<ul style="list-style-type: none"> • Assess all patients for co-morbid depression and, if present, receive appropriate psychological and medical management. • SSRIs are safe and efficacious for management of depression in patients with CHD (note potential interaction with warfarin) • Avoid use of Tricyclic Antidepressants in patients with CHD due to class III antiarrhythmic effect. • Cognitive-behavioural therapy (alone or in combination with medication) is also efficacious in depression management. 								
Social Management	<ul style="list-style-type: none"> • Assess all patients for level of social support and provide follow-up for those considered at risk through referral to cardiac rehabilitation services and/or to social worker or psychologist. Consider role of patient support groups. 								

¹ Adapted version developed by the project steering committee for use in the Fremantle Regional Division of General Practice

² For more details see the complete version of 'Reducing risk in Heart Disease -guidelines for preventing cardiovascular events in people with coronary heart disease' available at www.heartfoundation.com.au or from Heartline (ph: 1300 36 27 87).

³ This guide can also be used for those with other manifestations of atherosclerosis (eg aortic, carotid, and peripheral vascular disease)

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