

This Quick Reference Guide provides a summary of the main recommendations in the Scottish Intercollegiate Guidelines Network (SIGN) guideline on the management of stable angina.

SIGN's aim is to improve the quality of health care for patients in Scotland by reducing variation in practice which affects patient outcomes, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence.

The recommendations are graded **A B C** to indicate the strength of the supporting evidence. Good practice points are provided where the guideline development group wish to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations and their application in practice can be found in the full guideline, available on the SIGN website. This guideline was issued in April 2001 and will be considered for review in 2003.

For more information about the SIGN programme, contact the SIGN Executive or see the website:

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SUSPECTED ANGINA

HISTORY

CLINICAL EXAMINATION

- Haemoglobin** to identify underlying anaemia
- Fasting blood glucose** to identify previously undiagnosed diabetes mellitus
- Full lipid profile**

B Resting 12-lead ECG *A normal ECG does not exclude the possibility of CHD*

Patients may be referred to a cardiologist at any point if symptoms or test results indicate. The following should be specifically referred:

- patients who appear to have had a previous MI on their initial ECG or other abnormality that the general practitioner considers significant
- patients who fail to respond to medical treatment having already had an ETT
- patients who have an ejection systolic murmur suggesting aortic stenosis

Patients with pain on minimal exertion, pain at rest (which may occur at night) or angina which appears to be progressing rapidly despite increasing medical treatment may have **unstable angina** and should be considered for **immediate** referral.

B **Exercise tolerance test (ETT)** for risk stratification

Myocardial perfusion imaging where ETT is not possible

B ETT should be performed whilst patients are taking their normal medication

- Patients should not be referred for ETT if:
 - they are physically incapable of performing the test
 - they may have aortic stenosis or cardiomyopathy
 - the results of stress testing would not affect management

RISK FACTOR MANAGEMENT

▶ SMOKING

B All patients with angina who smoke should be advised to stop

A Brief advice from a health professional, tailored self-help materials, individual and group counselling and antidepressants (with behavioural support) can increase smoking cessation

▶ HYPERTENSION

B All patients with angina should have **blood pressure assessed and managed**

▶ DIET

B Patients with angina should **modify their diet** in line with healthy eating advice

▶ EXERCISE

B All those with CHD should be encouraged to **increase their aerobic exercise levels** within the limits set by their disease state

▶ OVERWEIGHT

C All patients with CHD should be actively encouraged to **lose weight towards BMI <25**

▶ ALCOHOL

B Patients with CHD who consume alcohol should be encouraged to limit their consumption to **three units per day for men** and **two units per day for women**

▶ LIPIDS

C All patients with angina should have a **cholesterol measurement**

If total cholesterol (TC) is ≥ 5.0 mmol/l

C **Appropriate dietary measures** should be recommended and a random **non-fasting cholesterol measurement** repeated after 6-12 weeks

C If required, **drug therapy** should then be initiated to reduce TC to < 5.0 mmol/l

DRUG THERAPY

▶ SECONDARY PROPHYLACTIC TREATMENT

A Patients with stable angina should be treated with **aspirin** 75 mg daily (unless contraindicated)

▶ SHORT TERM CONTROL OF ANGINA SYMPTOMS

All patients with symptomatic coronary heart disease should be prescribed **sublingual GTN** and should be educated in its use

▶ LONG TERM PREVENTION OF ANGINA SYMPTOMS

B **Patients who require regular symptomatic treatment should be treated initially with a β -blocker** (unless specifically contraindicated)

B Patients should be warned not to stop β -blockers suddenly or allow them to run out

C **Patients intolerant of β -blockers** and who show no LVSD should be treated with:

- a **rate limiting calcium channel blocker**
- a **long-acting dihydropyridine**
- a **nitrate**
- or a **potassium channel opening agent**

A If symptoms are not controlled in patients taking β -blockers, add:

- **isosorbide mononitrate**
- a **long-acting dihydropyridine**
- or **diltiazem** (but observe the cautions in the BNF)

▶ REFERRAL

Consideration should be given to referral to a cardiologist

- on initiation of treatment
- if the patient is perceived to be at increased risk
- if at any stage medical treatment fails to control symptoms
- or if these symptoms limit the patients' desired activities