Management options in patients with a definite diagnosis of stable angina

Definite diagnosis of stable angina
(eg known obstructive CAD, clear history)

Introduce or increase antianginal therapy
Review secondary prevention
(see sections 4 and 5.5 of full guideline)

Suitable for risk stratification with functional assessment?
(eg exercise tolerance test, myocardial perfusion scintigraphy, stress echocardiogram, perfusion CMR imaging)

No
Yes

Optimise medical therapy

Invasive coronary angiography*
("taking into consideration renal function, age, comorbidities")

Suitable for revascularisation?

No
Yes

Optimise medical therapy

Ongoing symptoms despite optimal medication?

No
Yes

PCI or CABG

Abbreviations: CAD – coronary artery disease CMR – cardiac magnetic resonance imaging PCI – percutaneous coronary intervention CABG – coronary artery bypass grafting
The following recommendations were highlighted by the guideline development group as key areas of update that should be prioritised for implementation.

Diagnosis and assessment

**R** Computerised tomography-coronary angiography should be considered for the investigation of patients with chest pain in whom the diagnosis of stable angina is suspected but not clear from history alone.

**R** In patients with suspected stable angina, the exercise tolerance test should not be used routinely as a first-line diagnostic tool.

Stable angina and non-cardiac surgery

**R** The routine use of aspirin to reduce perioperative cardiac events in patients undergoing non-cardiac surgery, including those with known stable coronary artery disease (CAD), is not recommended.

Investigation of patients with suspected angina

Clinical history is the key component in the evaluation of patients with angina. Often the diagnosis can be made on the basis of clinical history alone. Characteristics used to determine the diagnosis include nature and location of the discomfort, the duration of and relationship to exertion, as well as precipitating or relieving factors. Based on the history, patients can be categorised into three groups:

1) Patients with a clear history suggestive of stable angina (definite)
2) Patients with some features in the history suggestive of angina (suspected)
3) Patients describing non-cardiac chest pain (non-cardiac)

The following algorithms are suggested for the investigation and management of patients with 1) definite angina and 2) suspected angina. Patients with non-cardiac chest pain do not require further investigation for myocardial ischaemia.

**Abbreviations**

CT – computerised tomography    CAD – coronary artery disease    PCI – percutaneous coronary intervention    CABG – coronary artery bypass grafting