The authors and reviewers have made every attempt to ensure the information in the Family Medicine Clinical Cards is correct – it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Cards are not meant to replace customized patient assessment nor clinical judgment. They are meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when these cards are used.

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Ischemic Heart Disease Mgmt.

	Modifiable Risks	IHD RR*
Protective	- Exercise (aerobic, moderate intensity, 3-4x per week)	0.58
	- Mediterranean diet (olive oil, vegetables, grains, nuts, fish)	0.60
	- Light to moderate EtOH (<30g per day)	0.70
Threatening	- Periodontal disease	1.20
	- Elevated childhood BMI	1.22
	- Disturbed, short sleep (<6 hours)	1.55
	- Depression	1.60
	- Smoking (20 cigarettes per day)	1.78
	- Waist circumference: Men > 101.6 cm, Women > 89 cm	2.00

*RR = Relative Risk

Secondary Management of Ischemic Heart Disease

	Therapy	Guidance	RRR
Long - Term Therapy	**Cardiac Rehab**	- Home or hospital-based programs shown to reduce infarction/ cardiovascular mortality at 1 year post MI	28%
	Anti-Hypertensive	- Target BP <140/90 - *See Hypertension card*	10-30%
	ASA	- 75- 162 mg daily (use clopidogrel if intolerant)	10-15%
	ACE-Inhibitor	- Strongest evidence of benefit after MI: -ramipril, perindopril - If intolerant or contraindicated substitute with ARB - Do not combine with ARB - Stop if hyperkalemic or rise in Cr >30% above baseline	20%
	Statin	- Titrate to max dose with: -rosuvastatin, atorvastatin, simvastatin - Titrate to moderate dose if risk for statin assoc. events -monitor for hepatotoxicity (ALT), myopathy (CK) - If intolerant consider substituting with niacin	10-30%
3 mo (life-long if LV dysfxn., HF)	**B-blocker**	- Strongest evidence of benefit post-MI: -metoprolol, carvedilol, bisoprolol - If intolerant or contraindicated, and experiencing angina, substitute with CCB + long acting nitrates - Start at low dose and titrate upwards	25%

Patient Context	Guidance on Management
- Sev. Hepatic Dz	→ reduce dose of metoprolol, carvedilol, some statins
- CKD / CRF	→ reduce dose of ACE-I, B-blockers, diuretics if GFR <50
- COPD	→ use ultra - cardioselective B-blocker (bisoprolol)
- Hx of PCI + stent	→ add P2Y12 Inhibitor (clopidogrel) for 12 months
- Diabetes	→ ensure good control, lifestyle; *see Type 2 Diabetes card*

⚠ Worsening angina → arrange for urgent/emergent cardiac care

NYHA Classes of Functional Capacity

- I – no limitation of physical activity
- II – ordinary activity results in dyspnea, palpitations, fatigue; relieved by rest
- III – less than ordinary activity results in dyspnea, palpitations; relieved by rest
- IV – physical activity not tolerated; dyspnea, palpitations may be present at rest

Long-term Surveillance Plan Following First Episode of IHD

- ❑ Hx: assess for barriers to therapy, modifiable risks, comorbidities
- ❑ PE: HF, arrhythmia, new/worsened bruit or murmur, abdo aorta status
- ❑ Invest: annual resting ECG, metabolic fitness (lipids, glucose, CBC, renal)
- ❑ Refer: consider cardiac care team (cardiologist, dietician, trainer as required)

Key References: Mancini GB, et al. Canadian Cardiovascular Society guidelines for the diagnosis and management of stable ischemic heart disease. *Can J Cardiol*. 2014;30(8):837-49. McAlister F, et al. Randomised trials of secondary prevention programmes in coronary heart disease: systematic review. *BMJ*. 2001;323(7319):957-62. Neal B, et al. Effects of ACE inhibitors, calcium antagonists, and other blood-pressure-lowering drugs: results of prospectively designed overviews of randomised trials. Blood pressure lowering treatment trialists' collaboration. *Lancet*. 2000;356(9246):1955-64.