Long Term IHD Management

Antiplatelet Durartion? 00:00

- DAPT for 1 year following an ACS (regardless of whether stented or not)
- Following stenting, usually at least 6 months of DAPT
- Stable IHD – SAPT with aspirin

Beta-blockers and ACE inhibitors 00:37

- Beta blockers
  - Start early in ACS because it helps with reducing myocardial stress
  - If there is no heart failure, any beta blocker works
  - If BP is a concern, can give a short acting agent like metoprolol
  - Avoid starting if there is severe acute decompensated heart failure
  - If EF < 40%, then give carvedilol or bisoprolol; metoprolol succinate is not available in Singapore
  - Increase to maximum tolerated dose
  - Beta blocker can also be used for anti-anginal effect, can titrate to symptomatic relief or to HR <60
- ACE inhibitors and ARB
  - Generally, for patients with EF < 40%
  - Class benefit
  - Can give common agents like ACEi (enalapril, lisinopril) and ARBs (losartan, valsartan)

Low dose anticoagulation with antiplatelet therapy? 05:27

- Not practiced in Singapore
- Rivaroxaban 2.5mg not available in Singapore
- While COMPASS trial does show some MACE reduction with additional low dose anticoagulation, there is increased bleeding risk
- Contextualising to our population, Asians have been observed to be more prone to bleeding – hence generally this is not recommended in Singapore

What do we look out for when we follow patients up in clinic? 7:17

- Residual disease: >50% residual disease post PCI or >50% stenosis in major epicardial vessels
- Ejection Fraction
  - If EF < 30-35% post MI, important to repeat echo in 3-4 months to guide decision for ICD implantation
  - If EF higher, then probably don't need to repeat so soon
- DAPT: Compliance, bleeding problems
- Targets
  - LDL: European guideliens - 1.4mmol/L, American guidelines - 1.8mmol/L; but high dose statins recommended up front
  - BP: Aim SBP < 140
  - Hba1c: <7 – Metformin and SGLT2 inhibitors have cardiovascular benefit
- Symptoms: Residual angina
- Jobs: For vocational drivers, need a stress test before returning to work

How do we assess for procedural fitness in patients with IHD? 11:51

- Emergent vs elective – Pre-op work up is generally for elective surgery
- Revised Lee Index to stratify risk
- If risk is low, can proceed with surgery
- If risk is moderate to high, then assess functional status (~2 flights of stairs)
  - If able to climb then can proceed to surgery

    - If have difficulty, can consider stress test – but pre-operative revascularisation has not been shown to improve cardiovascular outcomes hence patients need to be appropriately counselled

Safety of holding off antiplatelets for procedures? 14:20

- ACC/AHA Guidelines: If surgery is elective, try to give at least 6 months of DAPT
- ESC guidelines: Try to give at least 1 month of DAPT
- Most contemporary stents, okay to drop to hold off 1 antiplatelet after 1 month for purposes of procedures
- For recent stent insertion
    - Emergency procedure: Emergency surgery takes precedence – hence just stop if need be
    - Early procedure (e.g. cancer): At least 1 month DAPT then drop to SAPT for procedure
    - Truly elective procedure: Ideally 6 months DAPT then drop to SAPT for procedure
- Stable IHD
    - Stent: Keep SAPT
    - No stent: Discuss with surgeon whether to keep SAPT or to drop

What are anti anginal options? 17:23

- Beta blockers
- Nitrates: ISMN has advantage of once a day dosing, but if BP is a concern then small doses of ISDN may be more BP favourable
- Calcium channel blockers: E.g. Nifedipine
- Others: Ivabradine, Ranolazine, Trimetizidine

Take home points? 19:50

- Long term IHD management should be focused on the management of overall cardiovascular risk profile to reduce risk of future events