

Optimising Prescribing for Chronic Stable Angina

The guidance does NOT override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

NICE guidance CG126 published in July 2011 highlights a number of changes to the way in which stable angina should be diagnosed, monitored and treated. In view of this, the cardiac network has developed the following prescribing guidance.

Angina is the main symptom of myocardial ischaemia and is usually caused by atherosclerotic obstructive coronary artery disease restricting blood flow and therefore oxygen delivery to the heart muscle. The aim of management is to stop or minimise symptoms, and to improve quality of life and long-term morbidity and mortality. Management options include lifestyle advice, drug treatment and revascularisation using percutaneous or surgical techniques.

Overarching Principles of Management

- 1. Explore and address issues according to the person's needs**, which may include:
 - self-management skills such as pacing their activities and goal setting
 - concerns about the impact of stress, anxiety or depression on angina
 - advice about physical exertion including sexual activity.
- 2. Offer a short-acting nitrate for preventing and treating episodes of angina**
- 3. Offer people optimal drug treatment for the initial management of stable angina.**
Optimal drug treatment consists of one or two anti-anginal drugs as necessary plus drugs for secondary prevention of cardiovascular disease.
- 4. Offer either a beta blocker or a calcium channel blocker as first-line treatment for stable angina.**
 - Do not routinely offer other anti-anginal drugs as first-line treatment for stable angina
 - Review the person's response to treatment, including any side effects, 2–4 weeks after starting or changing drug treatment
- 5. Consider revascularisation (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI]) for people with stable angina whose symptoms are not satisfactorily controlled with optimal medical treatment**
- 6. Offer aspirin 75 mg daily for people with stable angina**
Take into account the risk of bleeding and comorbidities.
- 7. Offer statin treatment in line with SLCSN Lipid management guidelines** (www.slcsn.nhs.uk)
- 8. Offer treatment for high blood pressure in line with SLCSN Hypertension guidance** (www.slcsn.nhs.uk)
- 9. Consider angiotensin-converting enzyme (ACE) inhibitors for people with stable angina and diabetes.** Offer or continue ACE inhibitors for other conditions, in line with relevant NICE guidance.
- 10. Do not:**
 - Exclude people from treatment based on their age alone
 - Investigate or treat symptoms differently based on gender or ethnic group
 - Offer vitamins or fish oil. Inform people there is no evidence that they help stable angina
 - Offer transcutaneous electrical nerve stimulation (TENS), enhanced external counterpulsation (EECP) or acupuncture to manage stable angina

For more information on managing stable angina, including the advice, information and support which should be offered to patients see: <http://www.nice.org.uk/nicemedia/live/13549/55663/55663.pdf>

For NICE guidance on improving Medicines Adherence see: <http://www.nice.org.uk/guidance/CG76>

Medical therapy for chronic stable angina

Therapies to improve prognosis:

- Start aspirin 75mg daily
 - Start a generic statin and manage lipids in line with SLCSN guidance
 - Manage blood pressure in line with SLCSN hypertension guidance
- SLCSN guidance can be accessed at <http://www.slcsn.nhs.uk/prescribing.html>

Provide sublingual GTN for use as required

Therapies to prevent episodes of angina

FIRST LINE: Offer a beta-blocker, such as bisoprolol 5-10mg daily
Aim for heart rate between 50-60 beats per minute

If beta-blocker contraindicated or not tolerated consider a rate-controlling calcium channel blocker (diltiazem or verapamil)

If additional anti-anginal therapy is required add a dihydropyridine calcium channel blocker, such as amlodipine 5 - 10 mg daily

If both beta-blockers and calcium channel blockers are contraindicated or not tolerated consider monotherapy with:

- a long-acting nitrate or
- nicorandil or
- ivabradine* or
- ranolazine*

If rate-controlling calcium channel blocker is contraindicated or not tolerated consider a dihydropyridine calcium channel blocker (amlodipine)

If symptoms are not satisfactorily controlled, consider adding a long-acting nitrate, nicorandil or ranolazine*

If dihydropyridine calcium channel blocker is contraindicated or not tolerated consider adding a long-acting nitrate, nicorandil, ivabradine* or ranolazine*

If symptoms are not satisfactorily controlled, consider adding a long-acting nitrate, nicorandil, ivabradine* or ranolazine*

If symptoms are not adequately controlled, consider referral for revascularisation; an additional anti-anginal may be added whilst awaiting cardiology review

*Place of newer anti-anginal therapies

- **Ivabradine:** may be useful in symptomatic patients where heart rate remains > 60bpm despite optimal dose of beta-blocker or rate controlling calcium channel blocker; or where these rate controlling agents are contra-indicated or not tolerated
 - **Ranolazine:** may be useful in patients where the use of other options is limited by bradycardia or hypotension
- In some primary care organisations these drugs may require specialist initiation*