Chronic Coronary Disease

Stable angina · Medical therapy first — revascularization is for symptoms and for high-risk anatomy

OMT FIRST
stenting does not prevent MI

WHAT CHANGED *two long-held reflexes were overturned*

REVASCULARIZATION IS NOT PROGNOSTIC HERE

In stable disease, an invasive strategy did not reduce death or myocardial infarction compared with optimal medical therapy, even with moderate to severe ischemia. **It did improve angina and quality of life in symptomatic patients.** So **revascularize for symptoms**, not to prevent events — and be honest with the patient about that distinction.

BETA-BLOCKERS ARE NOT FOR EVERYONE

Long-term beta-blockade is no longer recommended in chronic coronary disease without a specific indication — that is, without **myocardial infarction in the past year, an ejection fraction of 50% or less, or another reason such as arrhythmia or angina control**. The reflex "everyone with coronary disease takes a beta-blocker" is out of date.

NEW ADDITIONS

SGLT2 inhibitors and GLP-1 receptor agonists are recommended in selected patients, including some without diabetes, and an **SGLT2 inhibitor is strongly recommended where the ejection fraction is 40% or less**, regardless of diabetes status. **Low-dose colchicine** may be considered to reduce recurrent events in stable atherosclerotic disease.

THE FOUNDATION *this is where the prognostic benefit actually lives*

Element	Detail
Lipid lowering	**High-intensity statin for everyone who tolerates it.** If the LDL remains above goal, **add ezetimibe, then a PCSK9 inhibitor or other adjunct**. This is among the strongest prognostic interventions available and is routinely under-titrated — **recheck the lipids and escalate rather than leaving the patient on a starting dose indefinitely**.
Antiplatelet	**Single antiplatelet therapy long term**, usually low-dose aspirin, with **clopidogrel a reasonable alternative**. **Dual therapy is not for stable disease** outside a defined post-stent or post-ACS window — the bleeding cost outweighs the benefit.
Blood pressure and diabetes	Treat to guideline targets. **An ACE inhibitor or ARB is indicated with hypertension, diabetes, chronic kidney disease or reduced ejection fraction**, and is not required in everyone else purely because they have coronary disease.
Lifestyle	**Smoking cessation is the highest-yield single action**, with pharmacotherapy offered rather than advice alone. Add **cardiac rehabilitation**, which is consistently effective and consistently under-referred, plus diet, weight and regular physical activity. **Influenza vaccination annually.**
Do not forget	**Screen for and treat depression**, which is common, worsens outcomes and reduces adherence. **Ask about erectile dysfunction** before it silently stops the medication, and remember **nitrates are contraindicated with phosphodiesterase-5 inhibitors**. **Address driving, flying and return to work explicitly**, since patients frequently restrict themselves far more than the guidance requires, and **review adherence at every visit** rather than assuming the prescription equals the intake.

CONTROLLING THE ANGINA *either class may be first — choose by comorbidity*

1. **First-line is a beta-blocker OR a calcium channel blocker** — the guideline treats them as equivalent starting points. **Choose by comorbidity**: a beta-blocker where there is prior infarction, reduced ejection fraction or a rate problem; a calcium channel blocker in asthma, or where vasospasm is suspected.
2. **Give everyone short-acting nitrate** for symptom relief and prophylactically before predictable exertion. **Teach the patient how and when to use it**, and what to do if the pain does not settle — this conversation is frequently skipped and is the patient's safety net.
3. **If symptoms persist, combine a beta-blocker with a dihydropyridine calcium channel blocker. Avoid combining a beta-blocker with verapamil or diltiazem** — the combination risks profound bradycardia and heart block.
5. **Before escalating, check the basics. Is the patient actually taking the drugs? Is the angina being driven by anemia, thyrotoxicosis, uncontrolled hypertension, tachyarrhythmia or heart failure?** And **is the pain even cardiac?** Treating the aggravating condition is often more effective than adding a fourth antianginal.

ANTIANGINAL DOSES *the agents named above, with the numbers*

Drug	Dose	Watch for
Metoprolol succinate or bisoprolol	**25-200 mg daily** · bisoprolol **2.5-10 mg daily**	Titrate to a resting rate around **55-60**. Avoid abrupt withdrawal (rebound angina).
Amlodipine	**5-10 mg daily**	Ankle edema. Safe to combine with a beta-blocker.
Isosorbide mononitrate	**30-120 mg daily**	Build in a **nitrate-free interval of 10-14 h** or tolerance develops within days.
Ranolazine	**500 mg BID**, up to **1000 mg BID**	Does not affect heart rate or BP, so useful when both are already low. **QT prolongation**; cap at 500 mg BID with diltiazem.
Ivabradine	**5 mg BID**, up to **7.5 mg BID**	Only in **sinus rhythm with a rate ≥ 70**. Causes luminous phosphenes.

WHEN TO INVOLVE THE CATH LAB *symptoms, or anatomy that changes prognosis*

REFER FOR REVASCULARIZATION

Angina that remains limiting despite optimal medical therapy, or where the patient cannot tolerate adequate treatment. **Left main disease, and multivessel disease with reduced left ventricular function**, remain indications where revascularization does improve prognosis. **Multivessel disease with diabetes generally favors bypass surgery over stenting**. Also refer where **non-invasive testing shows high-risk features**, or where the diagnosis itself remains genuinely uncertain.

SET EXPECTATIONS HONESTLY

Many patients believe a stent prevents heart attacks and prolongs life. In stable disease that is not what the evidence shows, and the conversation should say so plainly: **it is done to relieve symptoms**. Sham-controlled work has shown a substantial placebo component to the symptomatic benefit, which makes **a genuine trial of optimal medical therapy first** both evidence-based and fair to the patient. **Anti-anginal drugs must continue after revascularization**; a stent treats a lesion, not the disease.

PEARLS & PITFALLS

- **Stents relieve angina; they do not prevent infarction in stable disease.** Say that explicitly when consenting.
- **Do not continue a beta-blocker indefinitely by reflex** without recent infarction, reduced ejection fraction or another indication.
- **Titrate the statin.** Under-treated lipids are the commonest missed prognostic opportunity in this group.
- **Never combine a beta-blocker with verapamil or diltiazem** — bradycardia and heart block.
- **Look for anemia, thyrotoxicosis and arrhythmia** in worsening angina before adding another antianginal.
- **Refer to cardiac rehabilitation and treat depression.** Both change outcomes and both are routinely forgotten.

References: 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA guideline for the management of patients with chronic coronary disease · 2021 ACC/AHA/SCAI coronary artery revascularization guideline · ISCHEMIA · COURAGE · ORBITA · LoDoCo2.