NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Chronic Heart Disease, Pharmacological Management of Confirmed Diagnosis

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	2
Does this version include changes to clinical advice:	Yes
Date Approved:	26th January 2022
Date of Next Review:	31st January 2025
Lead Author:	Joanne Lindsay
Approval Group:	Medicines Utilisation Subcommittee of ADTC

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Pharmacological management of confirmed* diagnosis of CHD

*Diagnosis should be confirmed by secondary care assessment.

NHS Greater Glasgow and Clyde

Patients with coronary calcification or significant atherosclerosis reported on non-cardiac imaging should be treated with secondary prevention - commence statin and anti-platelet

IMMEDIATE RELIEF OF ANGINA

Sublingual nitrates as required or prophylactically

Ensure patient educated in GTN use:-
- Use before angina provoking activities
- Seek medical help if GTN fails to relieve symptoms within 15 minutes and 3 doses

PREVENTION OF NEW VASCULAR EVENTS

B-BLOCKERS
(*Unless contraindications e.g. asthma, bradycardia <50/min –see advice below*)

Prescribe **Bisoprolol 2.5mg once daily** and up-titrate as tolerated/required.

ANTIPLATELET AGENT
Prescribe **Aspirin 75mg once daily.**
If true aspirin intolerance/ history of peripheral vascular disease, TIA or CVA, then switch to **Clopidogrel 75mg once daily.**
Post stent or following ACS – prescribe as advised by cardiologist in accordance with GGC Antiplatelet guidelines

STATIN
Treat all patients with CHD, regardless of plasma cholesterol concentration. Prescribe **Atorvastatin 80mg once daily.** See GGC Cholesterol guidelines for further prescribing information.

ACE INHIBITOR
Consider commencing an ACE inhibitor for patients with a previous MI, hypertension, diabetes.

Post MI – Ramipril twice daily dosing may be started by the hospital. Continue and up-titrate to 5mg twice daily or max tolerated.

LONG-TERM ANTI-ANGINAL THERAPY

Angina with preserved LV function & no severe aortic stenosis

Aim for a heart rate of 50-60/min at rest if no symptomatic postural hypotension

If resting pulse <50/min, prescribe Amlodipine 5mg once daily (esp if high BP) or Nicorandil 10mg twice daily

NO ASTHMA

ASTHMA (only if since childhood or significant AFO reversibility on PFTs)

Prescribe a beta blocker
Bisoprolol 2.5mg once daily – Up-titrate as required for angina and heart rate control.

Prescribe a rate limiting calcium channel blocker e.g. Verapamil (start at 120mg daily SR) or Diltiazem (start at 180mg daily – use 120mg daily in older people) and up-titrate to 360mg daily if required for angina & heart rate control. See BNF for brand specific dosing.

If persistent symptoms unacceptable to the patient

Add isosorbide mononitrate
Standard release tablets are as clinically effective, though slightly more cost-effective than modified release preparations. Ensure a six-hour nitrate-free period to minimise tolerance.
Or add Amlodipine *(NEVER add a rate-limiting CCB eg Verapamil or Diltiazem to a beta blocker)*

Angina with LV dysfunction* and/or aortic stenosis**

**Aortic stenosis – refer

*LV dysfunction – See GGC Heart Failure Guidelines.
Do not use Verapamil or Diltiazem. If unable to use a beta-blocker, consider referral.
Amlodipine is the dihydropyridine of choice in patients with LV systolic dysfunction.

If persistent symptoms unacceptable to the patient

Add isosorbide mononitrate
Standard release tablets are as clinically effective, though slightly more cost-effective than modified release preparations. Ensure a six-hour nitrate-free period to minimise tolerance.
Or add Nicorandil

ON TWO ANTIANGINAL DRUGS AND PERSISTENT SYMPTOMS UNACCEPTABLE TO THE PATIENT?

Consider referral back to cardiology for consideration of revascularisation or additional medication

Lifestyle modification for patients with confirmed diagnosis of CHD

RISK FACTOR MANAGEMENT

Cholesterol – See GGC Cholesterol guidelines and overleaf re statins

Hypertension

_ Target BP on Rx is less than 130/80 for patients with CHD

_ Weight reduction & exercise

_ Modify alcohol intake

_ BP lowering treatment: see GGC hypertension guidelines for advice

Diabetes - Optimise glycaemic control for those with diabetes in line with GGC guidelines for diabetes

Smoking – see below

COMPLIANCE

- Can be poor in long term conditions, lessening the effect of secondary prevention measures
- Ensure the issue is addressed on a regular basis
- Offer referral to local Prescribing Support Pharmacist attached to GP practice

HEALTH RELATED BEHAVIOURS MODIFICATION

Training:

The NHGGC Health Improvement Team offers a wide range of relevant training courses for health care professionals (0141 201 4876)

Cardiac Rehabilitation

Patients who have had a confirmed diagnosis of CHD within the last 6 months, or a change in symptoms following a previously confirmed diagnosis, can be referred to the cardiac rehabilitation (CR) service. The CR service can offer information about the disease, address misconceptions, provide peer support and encourage health behaviour change on a one-to-one basis or within a group setting.

Community services to support health related behaviour change

There are a range of community-based services which can support behaviour change. For details about local services please access the Health Improvement Service Directory at the following address

http://infodir.nhsggc.org.uk/

The Public Health Resource Directory (PHRD) online publications directory holds an extensive range of health improvement and public health resources. Please access at the following address www.phrd.scot.nhs.uk

Smoking

Contact local smoking cessation adviser if patient wishes to stop now.

Other services available are: The Smoke Free pharmacy service & The “Want to Stop Smoking Now” leaflet available from PERL

Weight management

_ Weight Management - Encourage weight loss if BMI > 25kg/m. Refer to GGC Specialist or community weight management service or **Live Active**

_ Healthy eating -signpost patients who want support to change what they eat to the Eat Well Guide

Physical activity

Aim for at least 150 minutes per week of moderate intensity activity (enough to increase your breathing, but still able to talk).

If patient wants more support to get started, consider a **Live Active** referral via SCI gateway.

Alcohol

Recommended limits = 2 units/day or 14 units/ week for men and women

_ Use the FAST questionnaire to define hazardous drinking

_ Offer brief intervention if score 3-12

_ Consider referral to the local CAT if score >12 (dependent drinking)

For local details about the above services please access Health Improvement Service Directory at the following address

http://infodir.nhsggc.org.uk/