Reducing Risk in Heart Disease 2004

A summary guide for preventing cardiovascular events in people with coronary heart disease

National Heart Foundation of Australia
& Cardiac Society of Australia and New Zealand

Heart Foundation

LIFESTYLE / BEHAVIOURAL RISK FACTORS AND MANAGEMENT

Smoking

Goal: Complete cessation and avoidance of passive smoking.
- Refer to Quitline 131 848.
- Consider pharmacotherapy for patients smoking > 10 cigarettes per day.

Nutrition

Goal: Establishment/maintenance of healthy eating patterns, with saturated & trans fatty acid intake ≤ 8% of total energy intake.
- Refer to Heart Foundation 'Enjoy Healthy Eating' messages, Heartline 1300 36 27 87 or www.heartfoundation.com.au

Alcohol

Goal: Low risk alcohol consumption in those who drink.
- Advise those with hypertension to limit alcohol intake to no more than two standard drinks per day (men), one standard drink per day (women).

Physical Activity

Goal: At least 30 minutes of moderate intensity physical activity on five or more days per week (150 mins per week minimum).
- Begin at low intensity and gradually increase over several weeks, particularly in the post-acute event period.

Weight Management

Goal: Waist measurement ≤ 94 cm (males) or ≤ 80 cm (females); BMI < 25 kg/m²*.
- Set intermediate achievable goals.

BIOMEDICAL RISK FACTORS AND MEDICAL MANAGEMENT

Lipids

Goal: TC < 4.0 mmol/l; LDL-C < 2.5 mmol/l; HDL-C > 1.0 mmol/l; Triglycerides < 2.0 mmol/l.
- All patients should receive healthy eating advice.
- Statin therapy is recommended for patients with coronary heart disease (CHD) unless contraindicated, and in hospitalised patients, should be initiated during that admission.

Blood Pressure

Goal: Dependent on age and presence of diabetes; proteinuria; renal insufficiency:

Adults ≥ 65 (unless there is diabetes and/or renal insufficiency and/or proteinuria ≥ 0.25 g/day)	< 140/90 mm Hg
Adults < 65; and all adults with diabetes and/or renal insufficiency and or proteinuria 0.25 - 1 g/day	< 130/85 mm Hg
Adults with proteinuria > 1 g/day (with or without diabetes)	< 125/75 mm Hg

- Generally ACEI are recommended as first line antihypertensives in patients with CVD.

Diabetes

Goal: Identify undiagnosed Type 2 diabetes; maintain optimal BSL in those with diabetes (HbA1c ≤ 7%).
- Screen all patients with CHD for diabetes.
- Manage hyperglycaemia with lifestyle interventions and pharmacotherapy if indicated.

PHARMACOLOGICAL MANAGEMENT

Antiplatelet Agents
- Use aspirin 70-150mg/day for all unless contraindicated.
- Additional role for clopidogrel in patients with recurrent cardiac ischaemic events; stent implantation.

ACE Inhibitors (ACEI)
- Treat all patients unless contraindicated, and initiate early post-myocardial infarction in high-risk patients.
- Use angiotension II receptor antagonists for patients who develop unacceptable side effects on ACEIs.

Beta-blockers
- For most patients post acute coronary syndrome, unless contraindicated, and continue indefinitely especially in high-risk patients.

Statins
- For all patients with CHD unless contraindicated.
- In hospitalised patients, therapy should be initiated during that admission.

Anticoagulants
- Use warfarin in patients at high risk of thromboembolism post-myocardial infarction.
- Warfarin may sometimes be combined with aspirin - monitor closely for signs of bleeding.

NON-PHARMACOLOGICAL MANAGEMENT

Secondary Prevention/Cardiac Rehabilitation Programs
- All patients to have access to and be actively referred to a comprehensive secondary prevention/cardiac rehabilitation service.

Chest Pain Action Plan
- All patients to have written action plan to follow in event of chest pain, including advice on use of antianginal medication and emergency action (dial 000 for ambulance) if chest pain/discomfort is not completely relieved in 10-15 minutes.

PSYCHOSOCIAL FACTORS AND ASSESSMENT

Psychological Management
- Assess all patients for co-morbid depression and, if present, initiate appropriate psychological and medical management.
- SSRIs are safe and efficacious for management of depression in patients with CHD (note potential interaction with warfarin).
- Avoid use of tricyclic antidepressants in patients with CHD due to class III antiarrhythmic effect.
- Cognitive-behavioural therapy (alone or in combination with medication) is also efficacious in depression management.

Social Management
- Assess all patients for level of social support and provide follow-up for those considered at risk through referral to cardiac rehabilitation services and/or to social worker or psychologist. Consider role of patient support groups.

Note: This guide can also be used for those with other manifestations of atherosclerosis (e.g. aortic, carotid and peripheral vascular disease).
* Weight management goals based on studies of European populations and may not be appropriate for all ages and ethnic groups.

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This summary guide is based on the full guideline document: **Reducing Risk in Heart Disease 2004 - guidelines for preventing cardiovascular events in people with coronary heart disease.**
Full version and summary guide are available at www.heartfoundation.com.au or Heartline 1300 36 27 87 (local call cost).

Key points:

- The guidelines were developed using a consensus approach which involved an independent assessment of key Australian and international evidence-based clinical guidelines, scientific articles and trial data[1], which are incomplete in some areas.
- Recommendations are not necessarily congruent with current PBS criteria for eligibility for subsidy in all areas.
- The guidelines provide a general framework for appropriate practice, to be followed subject to the practitioner's judgement in each individual case. All treatments should be individualised according to the patient's comorbidities, drug tolerance, lifestyle/living circumstances and wishes.
- For all medications observe usual contraindications, be mindful of the potential for significant and possibly adverse drug interactions and allergies, and carefully monitor and review patients regularly.
- Where drug therapy is recommended for indefinite use, these recommendations have been based on the extrapolated findings of clinical trials which are by their nature of limited duration.
- Patients are often discharged from hospital after an acute coronary event on low doses of medications such as beta-blockers, ACE inhibitors and statins. In the majority of cases, it is recommended that the dose of each individual medication be increased to the recommended maximum target dose as required and tolerated.
- Any improvement in risk factors and movement towards the ideal risk factor 'goals' and 'targets' will be beneficial. Risk factor modification should be considered as a total package, so that for example, attention is not diverted from addressing smoking cessation while treating dyslipidaemia, hypertension and diabetes.
- Diabetes, renal impairment, and non-coronary heart disease manifestations of atherosclerosis such as cerebrovascular disease or peripheral vascular disease indicate higher risk for coronary events. Patients with coronary heart disease should be screened for these conditions and managed appropriately.
- It is important to monitor and support patients' adherence to lifestyle advice and medications on an ongoing basis - where appropriate consider using ancillary measures (e.g. special clinics, telephone support, 'coaching').

These guidelines are endorsed by:

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[1] Based on assessment of literature until February 2004. A full reference list is available at www.heartfoundation.com.au.

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