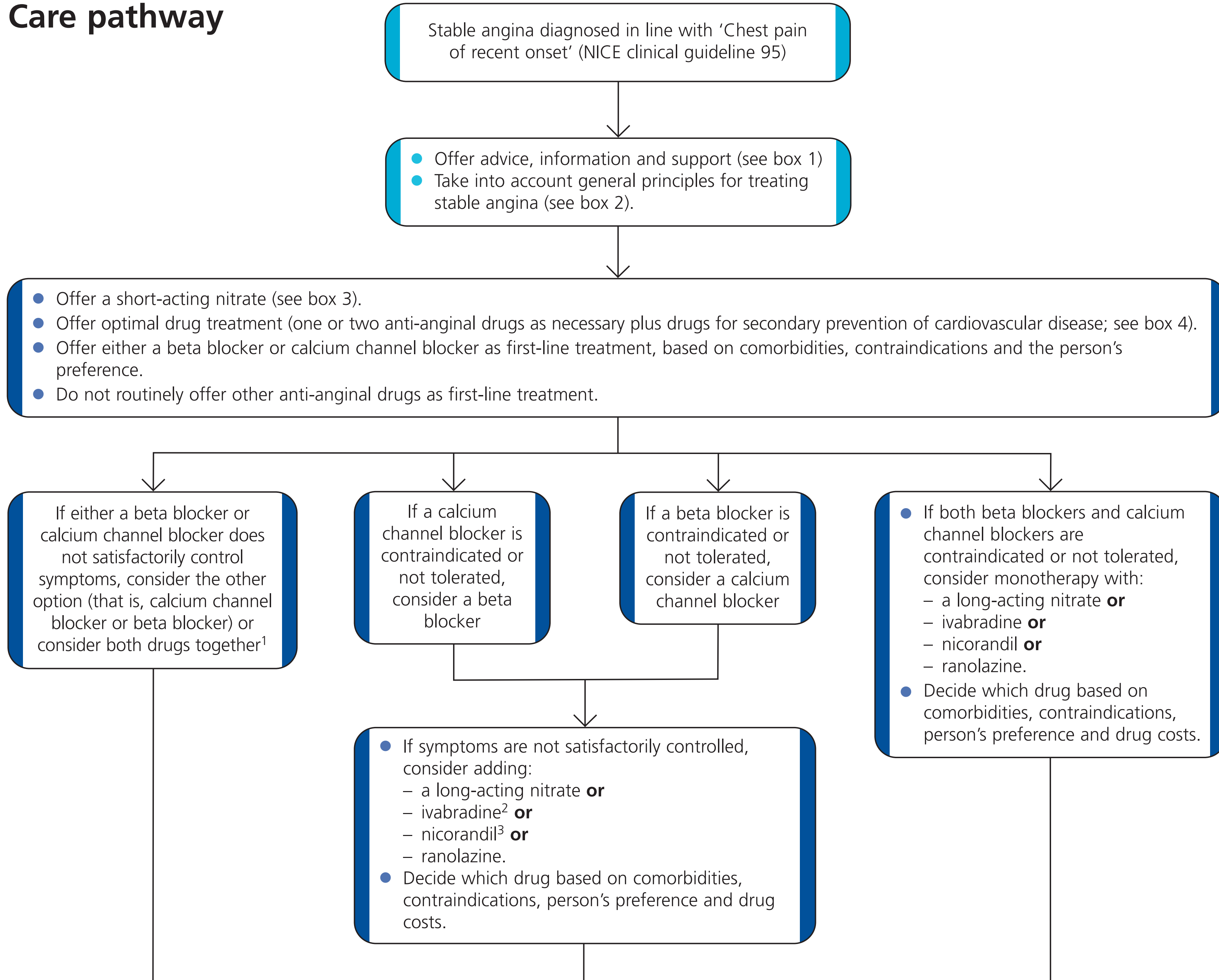
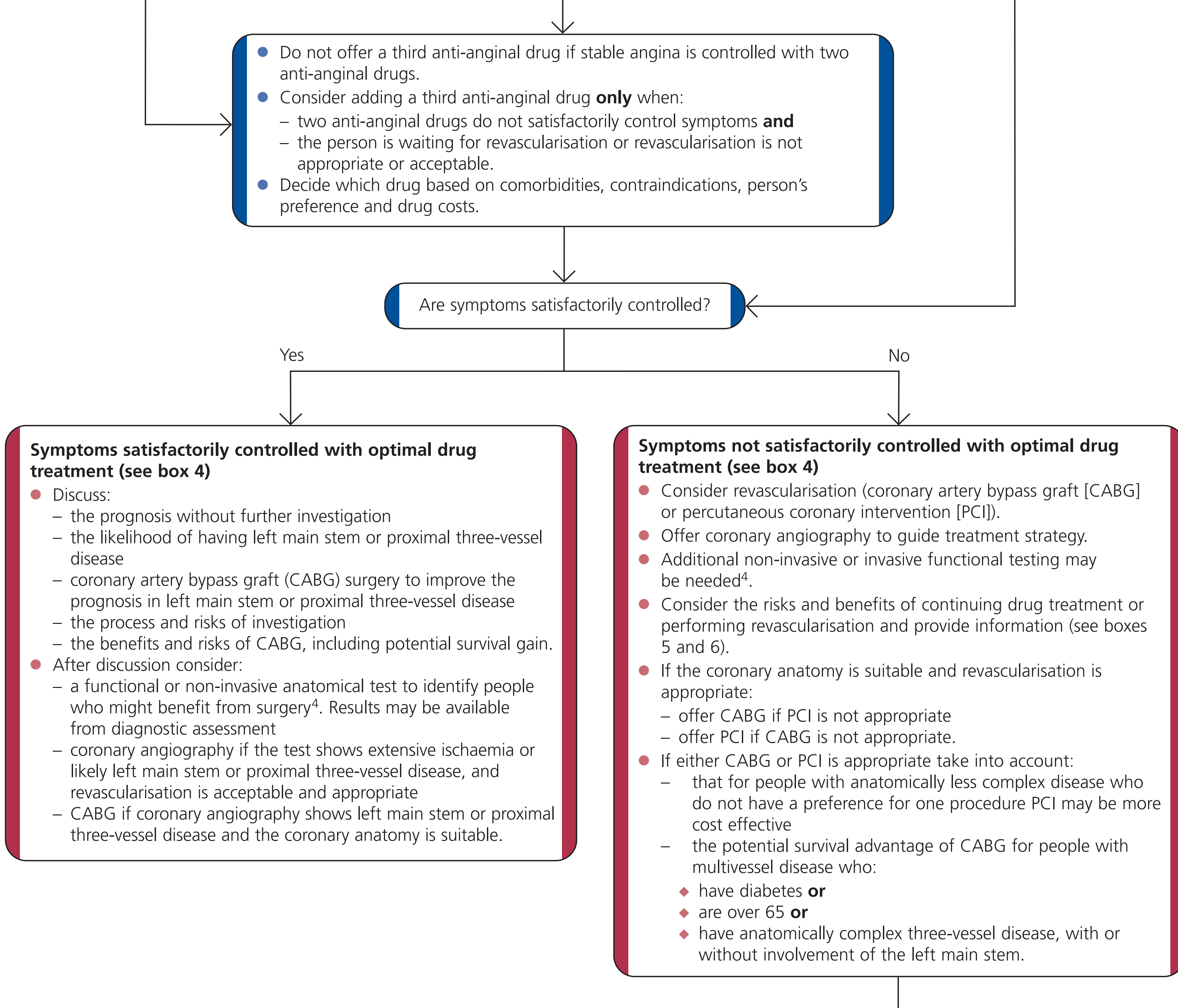
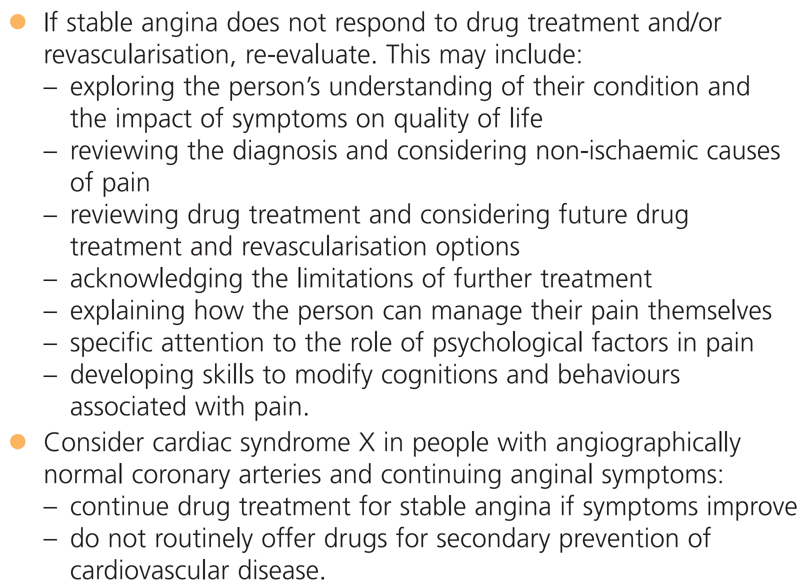
Care pathway




Do not offer a third anti-anginal drug if stable angina is controlled with two anti-anginal drugs.
Consider adding a third anti-anginal drug **only** when:
– two anti-anginal drugs do not satisfactorily control symptoms **and**
– the person is waiting for revascularisation or revascularisation is not appropriate or acceptable.
Decide which drug based on comorbidities, contraindications, person's preference and drug costs.
Are symptoms satisfactorily controlled?
Yes
No
Symptoms satisfactorily controlled with optimal drug treatment (see box 4)
Discuss:
– the prognosis without further investigation
– the likelihood of having left main stem or proximal three-vessel disease
– coronary artery bypass graft (CABG) surgery to improve the prognosis in left main stem or proximal three-vessel disease
– the process and risks of investigation
– the benefits and risks of CABG, including potential survival gain.
After discussion consider:
– a functional or non-invasive anatomical test to identify people who might benefit from surgery[4]. Results may be available from diagnostic assessment
– coronary angiography if the test shows extensive ischaemia or likely left main stem or proximal three-vessel disease, and revascularisation is acceptable and appropriate
– CABG if coronary angiography shows left main stem or proximal three-vessel disease and the coronary anatomy is suitable.
Symptoms not satisfactorily controlled with optimal drug treatment (see box 4)
Consider revascularisation (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI]).
Offer coronary angiography to guide treatment strategy.
Additional non-invasive or invasive functional testing may be needed[4].
Consider the risks and benefits of continuing drug treatment or performing revascularisation and provide information (see boxes 5 and 6).
If the coronary anatomy is suitable and revascularisation is appropriate:
– offer CABG if PCI is not appropriate
– offer PCI if CABG is not appropriate.
If either CABG or PCI is appropriate take into account:
– that for people with anatomically less complex disease who do not have a preference for one procedure PCI may be more cost effective
– the potential survival advantage of CABG for people with multivessel disease who:
◆ have diabetes **or**
◆ are over 65 **or**
◆ have anatomically complex three-vessel disease, with or without involvement of the left main stem.

Re-evaluation



- If stable angina does not respond to drug treatment and/or revascularisation, re-evaluate. This may include:
  - exploring the person's understanding of their condition and the impact of symptoms on quality of life
  - reviewing the diagnosis and considering non-ischaemic causes of pain
  - reviewing drug treatment and considering future drug treatment and revascularisation options
  - acknowledging the limitations of further treatment
  - explaining how the person can manage their pain themselves
  - specific attention to the role of psychological factors in pain
  - developing skills to modify cognitions and behaviours associated with pain.
- Consider cardiac syndrome X in people with angiographically normal coronary arteries and continuing anginal symptoms:
  - continue drug treatment for stable angina if symptoms improve
  - do not routinely offer drugs for secondary prevention of cardiovascular disease.

[1] When combining a calcium channel blocker with a beta blocker, use a dihydropyridine calcium channel blocker, for example, slow release nifedipine, amlodipine or felodipine.
[2] When combining ivabradine with a calcium channel blocker, use a dihydropyridine calcium channel blocker, for example, slow release nifedipine, amlodipine or felodipine.
[3] At the time of publication (July 2011), nicorandil did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.
[4] This partially updates recommendation 1.2 of 'Myocardial perfusion scintigraphy for the diagnosis and management of angina and myocardial infarction' (NICE technology appraisal guidance 73).