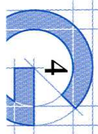
Care pathway

Stable angina diagnosed in line with '*Chest pain of recent onset*' (NICE clinical guideline 95)

- Offer advice, information, and support (see main text)
- Take into account general principles for treating stable angina (see main text)

Drug treatment

- Offer a short acting nitrate (see main text)
- Offer optimal drug treatment (one or two anti-anginal drugs as necessary plus drugs for secondary prevention of cardiovascular disease; see main text)
- Offer either a beta blocker or calcium channel blocker as first-line treatment, based on comorbidities, contraindications, and the person's preference
- Do not routinely offer other anti-anginal drugs as the first-line treatment



If either a beta blocker or calcium channel blocker does not satisfactorily control symptoms, consider the other option (that is, calcium channel blocker or beta blocker) or consider using both drugs together*

continued on next page

If a calcium channel blocker is contraindicated or not tolerated, consider a beta blocker

If a beta blocker is contraindicated or not tolerated, consider a calcium channel blocker

- If symptoms are not satisfactorily controlled, consider adding:
  - a long-acting nitrate or
  - ivabradine† or
  - nicorandil‡ or
  - ranolazine
- Decide which drug based on comorbidities, contraindications, person's preference, and drug costs

continued on next page

- If both beta blockers and calcium channel blockers are contraindicated or not tolerated, consider monotherapy with:
  - a long-acting nitrate **or**
  - ivabradine **or**
  - nicorandil **or**
  - ranolazine
- Decide which drug based on comorbidities, contraindications, person's preference, and drug costs

continued on next page

continued from previous page

continued from previous page

continued from previous page

Drug treatment

- 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

Revascularisation

Symptoms satisfactorily controlled with optimal drug treatment (see main text)

- 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

Symptoms not satisfactorily controlled with optimal drug treatment (see main text)

- Consider revascularisation (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI])
- Additional non-invasive or invasive functional testing may be needed§
- Consider the risks and benefits of continuing drug treatment or performing revascularisation and provide information

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 the 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

* When combining a calcium channel blocker with a beta blocker, use a dihydropyridine calcium channel blocker, for example, slow release nifedipine, amlodipine, or felodipine

† When combining ivabradine with a calcium channel blocker, use a dihydropyridine calcium channel blocker, for example, slow release nifedipine, amlodipine, or felodipine

‡ At the time of publication (July 2011), nicorandil did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented

§ 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)

STABLE ANGINA