

Update on the Evaluation and Treatment of Chronic Angina

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If there is one condition that defines cardiology, it is coronary artery disease. This is one of the most prevalent diseases and the number-one underlying cause of death worldwide. Chronic stable angina is the sine qua non of stable coronary artery disease; these patients have atherosclerosis but not an acute coronary syndrome (ACS). The latter is the acute exacerbation of stable angina, but accounts for just a few days (1-7 days in-hospital) in the life of a patient with coronary artery disease. Before an ACS event, most patients will have had the disease for a decade, or, more likely, for 2 to 3 decades (or even longer, it is hoped). As such, ACS management is key, but it accounts for only 1% of the patient's total time with the disease. Thus, optimal management of CAD and stable angina—in the chronic phase—is critical.

This supplement aims to update the reader on the many advances in the management of chronic stable angina. It begins with an article by Dr. Benjamin M. Scirica, who defines the problem and discusses the overall prevalence of the disease. Next, Drs. Prakash C. Deedwania and Enrique V. Cargajal review the current American College of Cardiology/American Heart Association Guidelines for the management of chronic angina. This article gives a clear listing of the evidence-based recommendations. In the next section, I cover the various approaches to management, including what medical therapies should be

applied to all patients and which patients should be referred for revascularization. Importantly, there are dual goals of management: one is to reduce symptoms of angina, and the other is to reduce the risk of cardiovascular events. Some therapies work for one goal, some for the other, and a few for both.

Risk stratification is a key component of therapy selection, and Drs. Norman E. Lepor and Gerald M. Pohost present a terrific article on the use of cardiovascular imaging to risk stratify patients with angina—with a goal of not simply defining prognosis but to help make treatment decisions.

Next, there are 2 interesting articles on the antiarrhythmic properties and effects of the newest class of drugs to be used for chronic angina, the late sodium channel blockers. Drs. Nathan J. Foster and David E. Haines examine the antiarrhythmic effects of ranolazine, a late sodium channel blocker. Drs. Darshan Doshi and John P. Morrow discuss the potential application of late sodium current blockade in the treatment of heart failure and atrial fibrillation. In this era in which there is increasing focus on the secondary effects of different agents, the finding of a potential beneficial side effect of an agent is refreshing.

All told, this supplement should bring you up to date on the current guidelines and the new data that have emerged since their publication, so as to provide a very current guide to management of chronic stable angina. ■

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