

# key points

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**Stable angina is estimated to affect more than 1.3 million** people in the UK with almost 100,000 new cases diagnosed each year. The prevalence of angina increases sharply with age. Around 50% of people diagnosed with ischaemic heart disease (IHD) present with stable angina as the first symptom.

**NICE recommends the classification of chest pain into** typical angina, atypical angina or non-anginal chest pain based on the presence of key features: a constricting discomfort in the front of the chest, or in the neck, shoulders, jaw or arms; precipitated by physical exertion; relieved by rest or GTN within about 5 minutes. The presence of all three features suggests a diagnosis of typical angina, two features is considered atypical angina and where one or none of the features are present the pain is defined as non-anginal. The likelihood of a diagnosis of angina increases with the number of cardiovascular risk factors present.

**A resting 12-lead ECG is recommended for all patients** with suspected angina. However, a normal result does not exclude the presence of underlying coronary artery disease (CAD). An abnormal resting ECG increases the likelihood that the patient has underlying CAD and may also identify other conditions such as atrial fibrillation or structural heart disease. In general, anatomical investigations, e.g. computerised tomography coronary angiography (CTCA), determine the presence of underlying CAD and identify individuals with a pattern of CAD that may benefit from revascularisation, while functional tests, e.g. exercise tolerance testing, evaluate the burden of myocardial ischaemia and facilitate risk stratification. In a randomised trial of more than 4,000 patients with a suspected diagnosis of angina, the addition of CTCA to standard care increased diagnostic accuracy and permitted targeting of therapy and interventions to those patients who gained most benefit.

**There is clear evidence that aspirin reduces the risk of** ischaemic events in patients with established CAD and it should be prescribed, where possible, for all patients with stable angina. There are robust data demonstrating that statins reduce the risk of death and MI in patients with IHD by 40%, and NICE currently recommends initiating treatment with atorvastatin 80 mg once daily. Treatment with an ACE inhibitor should be considered for patients with stable angina who have left ventricular dysfunction or diabetes mellitus.

**There are currently six major drug classes available in** the UK for the treatment of stable angina: beta-blockers, calcium channel blockers, nitrates, potassium channel activators, sinus node inhibitors and late sodium current inhibitors. Ideally, the dose of a single anti-anginal agent should be optimised before introducing combined therapy. There is little evidence to support the use of three anti-anginal drugs in combination. Beta-blockers should be used as first-line therapy, although evidence of a prognostic benefit in stable angina is limited.