

key points

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A detailed history is essential in patients with coronary artery disease (CAD) to elucidate red flag symptoms necessitating urgent specialist assessment. Red flags include syncope and presyncope, particularly in patients with concomitant left ventricular systolic dysfunction. Palpitations with severe chest pain and breathlessness also warrant urgent assessment.

Undiagnosed atrial fibrillation (AF) is common in older populations. In patients with stable CAD without an acute coronary syndrome (ACS) or percutaneous coronary intervention (PCI) in the preceding 12 months oral anticoagulation alone should be used. In the context of ACS or recent (preceding 12 months) PCI decisions on combination therapy should be undertaken in collaboration with the interventional cardiology team. Triple therapy for 1-6 months may be indicated, influenced by the specific stents used, coronary anatomy and patient specific bleeding risk. Dual therapy with oral anticoagulation and clopidogrel should then be continued up to 12 months followed by anticoagulation alone.

There is no clear evidence that a rhythm control strategy offers any significant long-term benefits in AF. The appropriate strategy is therefore determined primarily by the symptomatic burden of AF. Rate control is based on slowing AV nodal conduction. As beta-blockers are indicated for many patients with CAD, particularly following an ACS, this should be considered first line. The initial target heart rate should be < 110 . Flecainide is commonly prescribed for paroxysmal AF. It is contraindicated in patients with CAD because of an increased risk of sudden death. Catheter ablation should therefore particularly be considered in patients with severe symptoms and/or LV dysfunction. AF occurs in up to 50% of patients post CABG, but is often self-limiting within the first 4-6 weeks.

Premature ventricular complexes are also frequently observed in primary care and are therefore commonly seen in patients with stable CAD. In this context reassurance is usually all that is required. In patients with particularly bothersome symptoms of skipped or extra beats then beta-blockers may be indicated.

Left ventricular ejection fraction (LVEF) $\leq 35\%$ is a predictor of increased risk of sudden death. All patients with CAD should therefore undergo assessment of LVEF, usually by transthoracic echocardiography. This is particularly important at least 6 weeks following presentation with ST-elevation ACS. Most patients with CAD who experience ventricular arrhythmias will require an ICD.

Bradycardia in patients with stable CAD is most frequently related to rate limiting drugs such as beta-blockers resulting in sinus bradycardia with or without PR prolongation. In the absence of symptoms no intervention is required. The observation of second- or third-degree AV block requires specialist assessment.