Angina

- Common.
- 5% of > 40y.
- Atherosclerosis starts at 17y age.
- By the time angina felt, 70% blockage has already occurred.

Disclaimer:
Read the disclaimer at medimaps.co.uk/disclaimer

References:
1. cks.nice.org.uk
2. Cardiology consultant Russells Hall Hospital Feb 2018
3. Dr Yassir Javaid, GPwSI cardiology, Dec 2021.

Symptoms

- Tightness in chest, neck, jaw, shoulders, arms
- Onset with exertion
- Relieved with rest or GTN within 5 min

- Radiates due to visceral sensory nerves of the heart travelling next to the somatic nerves of the chest and arm.

3 symptoms = typical angina
2 symptoms = atypical angina
0/1 symptom = non-anginal chest pain

- Be aware: the degree of symptoms do not correlate well with the extent of CHD.

- If prolonged continous pain for 24 hr it's not MI.
- The pain goes away once the heart muscle is dead, which takes about 12 hr.

rule out unstable angina

- New onset within 24 hr
OR
- Abrupt deterioration in stable angina
OR
- Angina at rest
OR
- More 20 min
OR
- Autonomic symptoms (sweating, nausea)

- Refer to A&E STAT.

Investigations

- FBC.
- UEs.
- LFTs.
- Lipids.
- ECG.

- Pathological Q waves.
- LBBB.
- ST depression.
- T inversion.
- T flattening.

Management

- Start treatment in 1o care.
AND
- Refer to cardiology.

- To confirm Dx possibly using CT angiogram.
- Stenting has no role in stable angina.
- They will recommend medical management.

GTN spray

- Sit down.
- One dose.
- Wait 5 min.
- If fails, second dose.
- Wait 5 min.
- If fails, third dose.
- Wait 5 min.
- If fails 999.

Aspirin 75mg

- If classical Hx, then start aspirin.

Beta-blocker / Calcium channel blocker

- Beta-blocker.
OR
- Calcium channel blocker (non-dihydropyridine)

- Start bisoprolol 1.25mg for 2/52, then 2.5mg for 2/52, then 3.75mg for 2/52, then 5mg for 1/12, then 7.5mg for 1/12, then 10mg.
- Target HR 50-60.

- Cardiology consultant at Russell Hall Hospital states he starts even if asthmatic, as long as not unstable asthma.
- Advises that GP's can also start, but counsel and document your disucssion with the pt.
- If they get tight chest use salbutamol and stop taking, and will wear off.
- Improves COPD prognosis.

- S/e of lethargy in < 10%.
- Try to persevere.
- After 3-4/52 you will adapt.
- If not then stop.
- Use any cardio selective beta blocker e.g. bisoprolol, metoprolol, nebivolol, atenolol.

- Verapamil.
- Diltiazem.

*** Do not give betablocker and verapamil together ***

BP

- Aim < 130/80.

Statin

- Even if normal lipids as gives a plaque stabalising effect.
- Aim to reduce LDL by 40% or to 1.4'ish
- e.g. Atorvastatin 40mg-80mg

DVLA

Cars
- No need to notify.
- Stop when in pain.
- Continue when eased.

Lorries
- Tell DVLA.
- Tell insurance.
- Possibly allowed if 6/52 pain free.

Sex

- If can briskly climb up 2 flights of stairs without pain, sexual activity is unlikely to precipitate attack.
- If pain during sex does occur, stop.
- Next time can use GTN immediately before sex as prophylaxis.
- GTN and phosphodiesterase inhibitors concomitantly are contraindicated.

- Do not use GTN in the 24 hr before or after taking sildenafil (Viagra) or vardenafil (Levitra).
- Leave 48 hr with tadalafil (Cialis).

- Bisoprolol 1.25mg 2/52, then 2.5mg 2/52, then 3.75mg 2/52, then 5mg 1/12, then 7.5mg 1/12, then 10mg.
- ↓ myocardial O2 demand & ↑ coronary flow.

- Diltiazem.
- Dilate peripheral and coronary arteries & rate limiting.

- Nitrate.
- Venodilation ↓ preload & dilate peripheral and coronary arteries.

- Ivabradine 5mg BD 4/52 then 7.5mg BD if required.
- Sinus node If channel inhibitor (funny channel) & no effect on BP.

- Ranolazine 375mg BD 2-4/52, then 500mg BD, then 750mg BD if needed.
- Inhibits Na+ channels, ↓ intracellular Na+ and Ca2+ & minimal effect on BP and HR.