Reducing risk in heart disease

An expert guide to clinical practice for secondary prevention of coronary heart disease – summary

Updated 2012

This summary guide is based on the full guide document: Reducing risk in heart disease: an expert guide to clinical practice for secondary prevention of coronary heart disease (updated 2012). Call the Health Information Service on 1300 36 27 87 or visit www.heartfoundation.org.au for a copy.

Endorsed by:
# Reducing risk in heart disease

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## Lifestyle/behavioural risk factors and management

### Smoking

**Goal:** Complete cessation of smoking and avoidance of second-hand smoke.

### Nutrition

**Goals:** Establishment and maintenance of healthy eating patterns including:
- Saturated fatty acid < 7% and trans fatty acid < 1% of total energy intake
- Consumption of 1 g eicosapentaenoic acid (EPA) + docosahexaenoic acid (DHA) and > 2 g alpha linolenic acid (ALA) daily
- Limiting salt intake to ≤ 4 g/day (1550 mg sodium).

### Alcohol

**Goal:** Consumption of a low-risk amount of alcohol by patients who drink.

### Physical activity

**Goal:** Progress, over time, to at least 30 minutes of moderate-intensity* physical activity on most, if not all, days of the week (150 minutes/week minimum).

### Healthy weight

**Goals:**
- Waist measurement < 94 cm (men) and < 80 cm (women)
- Body mass index (BMI) = 18.5–24.9 kg/m²

## Biomedical risk factors/medical management

### Lipids

**Goals:**
- Low-density lipoprotein cholesterol (LDL-C) < 1.8 mmol/L
- High-density lipoprotein cholesterol (HDL-C) > 1.0 mmol/L
- Triglyceride (TG) < 2.0 mmol/L
- Non–high-density lipoprotein cholesterol (NHDL-C) < 2.5 mmol/L

### Blood pressure

**Goal:** Patients with coronary heart disease (CHD) achieve and maintain a blood pressure (BP) of < 130/80 mmHg.

### Diabetes

**Goal:** Patients with previously undiagnosed type 2 diabetes are identified. In patients with diabetes, aim to maintain optimal blood sugar level (BSL) (HbA1c ≤ 7%).

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* Moderate-intensity physical activity causes a moderate, noticeable increase in depth and rate of breathing, while still leaving you able to talk comfortably. Examples include brisk walking on level firm ground, swimming, water exercise and cycling for pleasure or transport.

† Goals are based mainly on evidence of increased risk of death in European populations. They may not be appropriate for all age groups and ethnic groups.

‡ This target is for high-risk patients who have had a coronary event.

§ NHDL-C is calculated by subtracting HDL-C from total cholesterol (TC). It combines LDL-C, very low density lipoprotein cholesterol (VLDL-C), intermediate density lipoprotein (IDL-C) and lipoprotein (a) (LP(a)). The NHDL-C does not assume normal lipoprotein composition, does not require a fasting specimen, and may be a better indicator than LDL-C in patients with high TG (such as patients with diabetes).

**This includes patients with or without diabetes and/or stroke/transient ischaemic attack (TIA) and/or microalbuminuria (men > 2.5 mg/mmol, women > 3.5 mg/mmol).
## Pharmacological management

### Antiplatelet agents
- All patients should take 75–150 mg/day of aspirin unless contraindicated.
- Addition of clopidogrel may be relevant in patients with recurrent ischaemic events, post-stent implantation.
- Prasugrel and ticagrelor are alternatives to clopidogrel in patients with acute coronary syndromes (ACS).

### Anticoagulants
- Use warfarin in patients at high risk of thromboembolism post–myocardial infarction (MI).
- Monitor closely for signs of bleeding, particularly when combined with antiplatelets.

### ACE inhibitors (ACEIs)/Angiotensin II receptor antagonists (ARAs)
- We recommend ACEIs in all patients, especially those at high risk, unless contraindicated. Start early post-MI.
- Consider ARAs for patients who develop unacceptable side effects on ACEIs.

### Beta-blockers
- We recommend beta-blockers in all patients post-MI, especially in high-risk patients, unless contraindicated.

### Statins
- We recommend statins in all patients with CHD, unless contraindicated.
- For hospitalised patients, therapy should start during admission.

### Aldosterone antagonists
- Eplerenone may be used early post-MI in patients with left ventricular systolic dysfunction and symptoms of heart failure.

### Short-acting nitrates
- All patients should be prescribed a short-acting nitrate, unless contraindicated, and provided with a written action plan for chest pain.

## Initiating and sustaining behaviour change

### Secondary prevention/cardiac rehabilitation (SP/CR) programs
**Goal:** All patients have access to comprehensive ongoing risk factor modification and cardiac rehabilitation services.

### Warning signs of heart attack: action plan
**Goal:** Everyone with CHD is prescribed a short-acting nitrate, unless contraindicated, and given an action plan to follow if they experience warning signs of heart attack.

## Psychosocial factors and assessment

### Psychological management
**Goal:** Assess all patients for comorbid depression. Initiate psychological and medical management if appropriate.

### Social support
**Goal:** Assess all patients for their level of social support.
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References


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