

# Management of Chronic Stable Angina



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## KEYWORDS

- Chronic stable angina • Quality of life • Ischemic heart disease
- Congestive heart failure

## KEY POINTS

- Chronic stable angina is diagnosed when symptoms are present for at least 2 months without changes in severity, character, or triggering circumstances.
- Chronic stable angina symptoms are predictable in frequency, severity, duration, and provocation.
- Current treatment strategies are aimed to prevent progression of atherosclerosis, control symptoms, and improve quality of life for the individual.
- Management of chronic stable angina requires a multifaceted treatment modality.

Chronic stable angina (CSA) is a symptomatic problem that is precipitated by ischemic heart disease. Ischemic heart disease, also referred to as coronary heart disease, is diagnosed when there is an inadequate supply of blood to the myocardium.<sup>1</sup> Ischemic heart disease may present as stable or unstable angina. CSA is diagnosed when symptoms are present for at least 2 months without changes in severity, character, or triggering circumstances.<sup>2</sup> CSA is provoked by exertion and relieved by rest because myocardial supply and demand are determinants of the coronary ischemia. CSA symptoms are predictable in frequency, severity, duration, and provocation. The clinical presentation should be evaluated with a detailed history of angina quality, location, radiation, severity, duration, and precipitating and relieving factors. Angina history with associated factors and medications should be elicited from the client (**Table 1**).<sup>2</sup> Current treatment strategies are aimed to prevent progression of atherosclerosis, control symptoms, and improve quality of life for the individual.<sup>2</sup>

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<b>Table 1 Angina history</b>	
Precipitating factors	Activity related to ADL and walking Meals Stress Cold
Angina Characteristics	Quality of the pain (pressure, stabbing, tightness burning) Radiation (left arm, shoulder, back, neck, jaw) Relief measures (rest, use of nitroglycerin) Severity of pain (rate on numeric pain scale) Timing (activity, times of stress, and note duration of angina event)
Associated Factors	Diaphoresis Dyspnea Paroxysmal nocturnal dyspnea Orthopnea (assess how they sleep: number of pillows or sleeps in a recliner) Gastrointestinal complaints (nausea, vomiting) Fatigue
Medication Profile	Encourage to carry current medication list Review list for medication adherence

Data from Tarkin J, Kaski J. Pharmacological treatment of chronic stable angina pectoris. *Clin Med* 2013;13(1):63–70.

## STRATEGIES TO PREVENT DISEASE PROGRESSION

Management of CSA requires a multifaceted treatment modality. The provider and client's goal should be to slow the ischemic heart disease progression through the ranks of heart failure. Clients should initially undergo noninvasive stress testing and echocardiography to determine left ventricular function.<sup>3</sup> Coronary angiography is appropriate when information from the procedure will significantly influence patient management or if a patient is a candidate for percutaneous coronary intervention (PCI) or surgical revascularization. Current guidelines recommend that optimal medical therapies and lifestyle modification be the first-line treatment of low-risk patients with CSA.<sup>4</sup> In CSA, the choice to pursue PCI is elective. The risks associated with PCI, which include myocardial infarction, restenosis, and death, come with no added benefit of decreased morbidity and mortality in the CSA client.<sup>4</sup>

Optimal medical therapies should include acetylsalicylic acid, beta blockers, calcium channel blockers, lipid-lowering agents, and nitrates as needed.<sup>3</sup> Aspirin therapy doses of 75 mg to 325 mg daily are associated with the best risk–benefit ratio.<sup>1</sup> Clients at risk for gastrointestinal bleeding should be treated with 81 mg per day, plus a proton pump inhibitor. Clopidogrel is an alternative in clients allergic to aspirin.<sup>1</sup> In the client who presents with congestive heart failure with left ventricular ejection fraction (LVEF) less than 40%, the recommendations suggest a renin-angiotensin system inhibition treatment with an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB), or an angiotensin receptor neprilysin inhibitor (ARNI).<sup>5</sup> ARNI is a combination of an ARB with an inhibitor of neprilysin (valsartan-sacubitril), which is an enzyme that degrades natriuretic peptides, bradykinin, adrenomedullin, and other vasoactive peptides.<sup>5</sup> In random controlled trials, ARNI reduced cardiovascular death and heart failure hospitalizations. The client taking ARNI should be monitored for hypotension, renal insufficiency, and angioedema.

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