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HEART INSTITUTE

Coronary Syndromes for Primary Care

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CME Accreditation and Disclosure

- No commercial support was provided.
- No relevant financial relationships to disclose.
- Soley based on ACC/AHA clinical practice guidelines.

Learning Objectives

- Interpret guideline changes for acute coronary syndrome (ACS) and stable ischemic heart disease, now called chronic coronary disease(CCD).
- Implement updated diagnostic and treatment strategies.
- Improve patient outcomes with evidence-based management.

ACS: What PCPs Need to Know

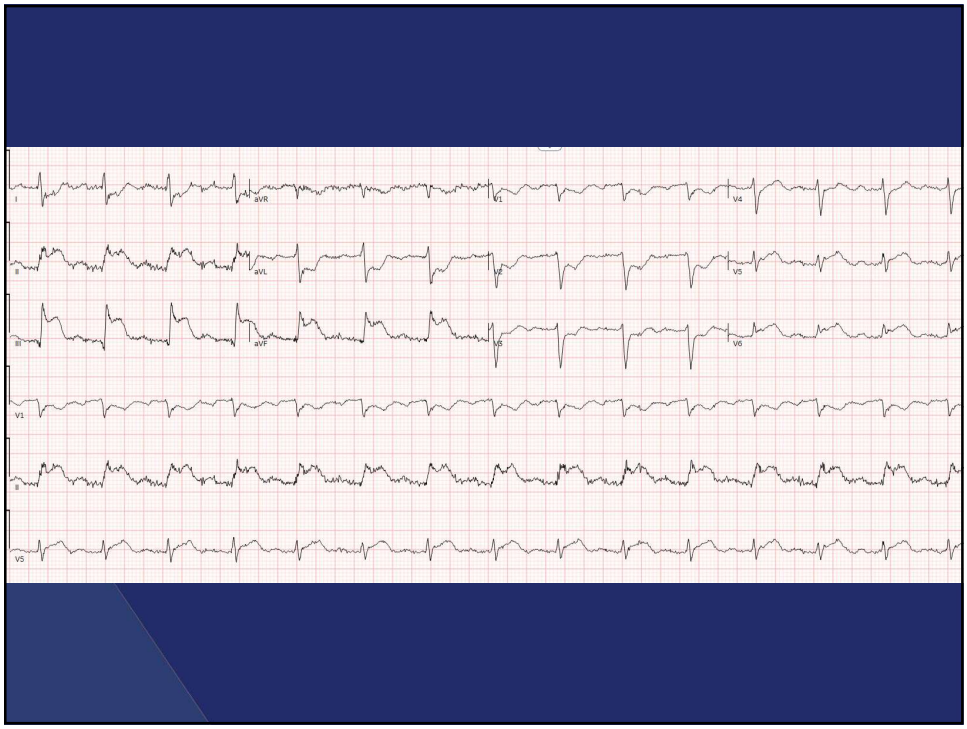
- STE-ACS (STEMI) and NSTE-ACS (NSTEMI/Unstable Angina)
- Early recognition and rapid referral saves myocardium and lives
- Primary care role
  - **Recognition – Symptoms and ECG**
  - Stabilization
  - **Transition of care**

Initial Evaluation of Suspected ACS

- Vitals, symptoms, and risk factors
- ECG within 10 minutes
- Activate EMS for high-risk presentations

Recognition

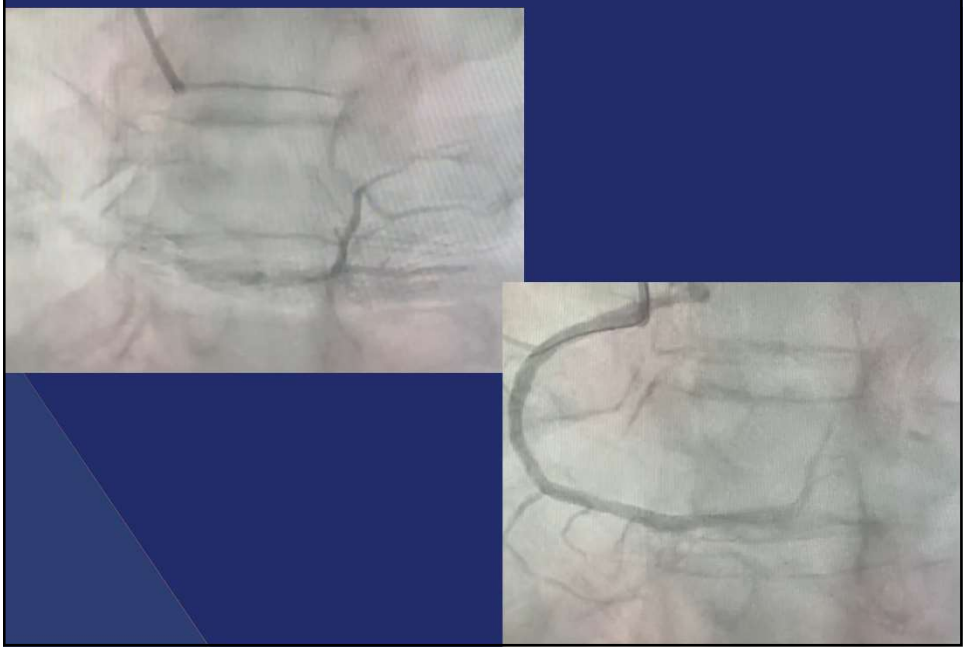
- 77-year-old man with type II diabetes mellitus, hypertension, hyperlipidemia, obesity, and hyperlipidemia woke up with dull achiness in his chest and went in for a scheduled check-up with PCP.
- An ECG was performed.



Core Medical Therapy in ACS

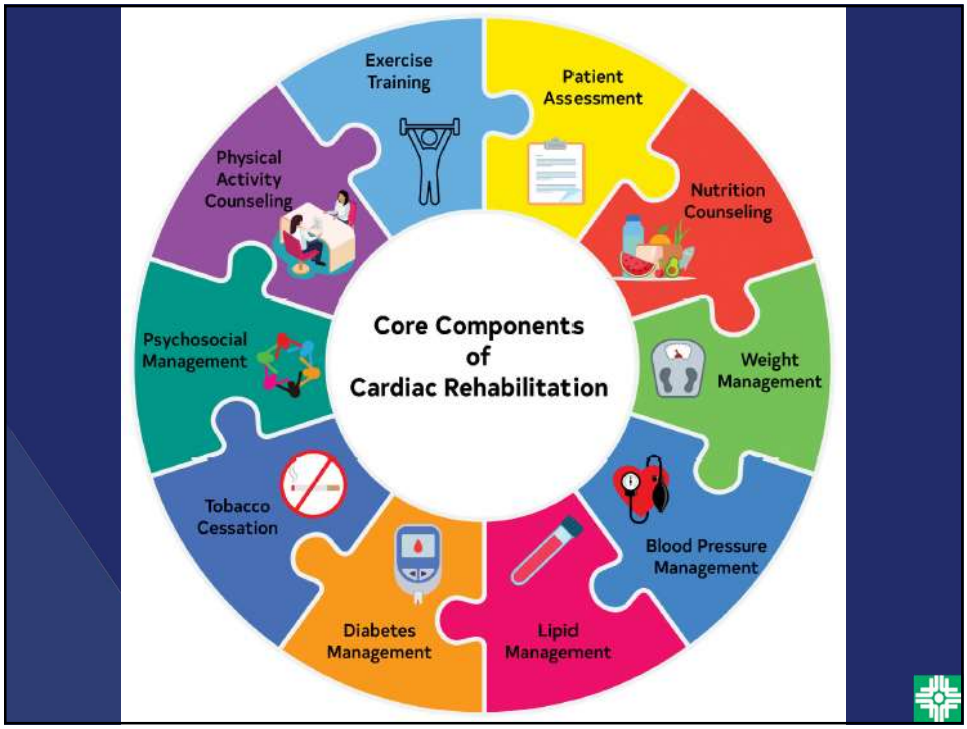
- Aspirin 324mg chewable for all patients without contraindication
- Dual antiplatelet therapy (DAPT) for most patients
- High-intensity statin therapy initiated early

Stabilization



Transition of Care

- Post-ACS Discharge: Primary Care Focus
  - Ensure **adherence** to DAPT and lipid-lowering therapy
  - Check lipid panel 4-8 weeks after discharge
  - Cardiac rehabilitation
  - Annual influenza vaccination



Key Updates in ACS

- Ticagrelor/Prasugrel > Clopidogrel (unless AC)
- 12mo DAPT
  - GIB risk --> PPI (avoid CYP P450)
- LDL goal <70, <55
- Radial approach
- Intracoronary imaging
- Complete revascularization
- Microaxial flow pump
- Liberal transfusion
- Lipid panel 4-8 weeks and cardiac rehab

From ACS to CCD

- Transition from ACS to CCD after stabilization
- Primary care plays a central role in long-term management.
- Focus on symptom control and prevention of future events.

What is CCD?

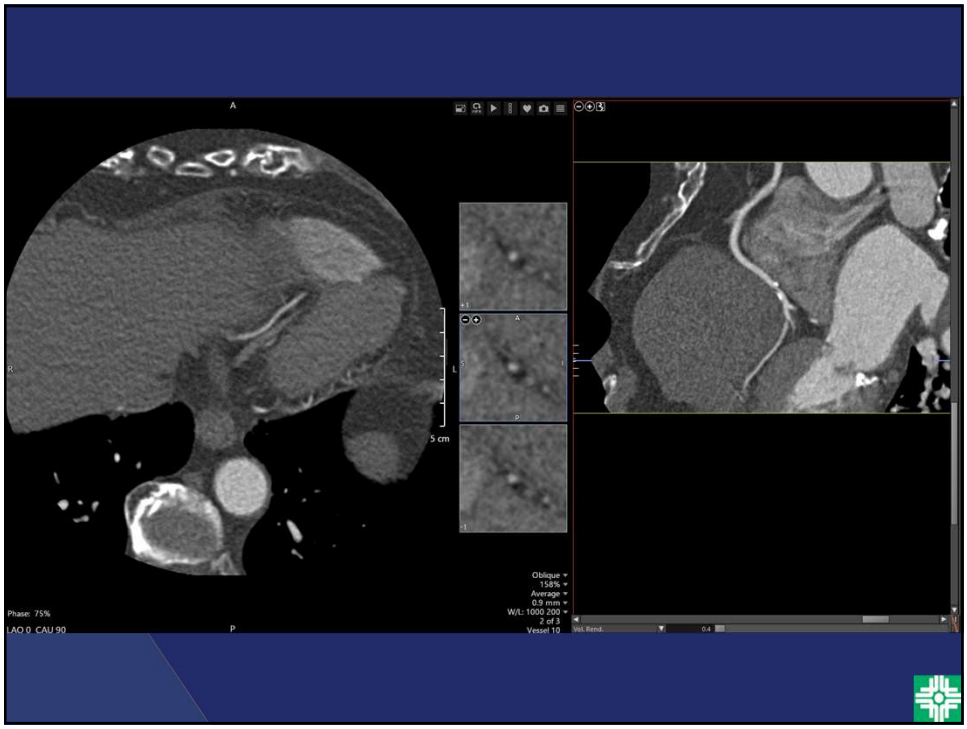
- Prior MI or coronary revascularization
- Stable angina or ischemic equivalent
- Ischemic cardiomyopathy or documented coronary disease
- Angina, coronary vasospasm/microvascular angina
- Positive screening test

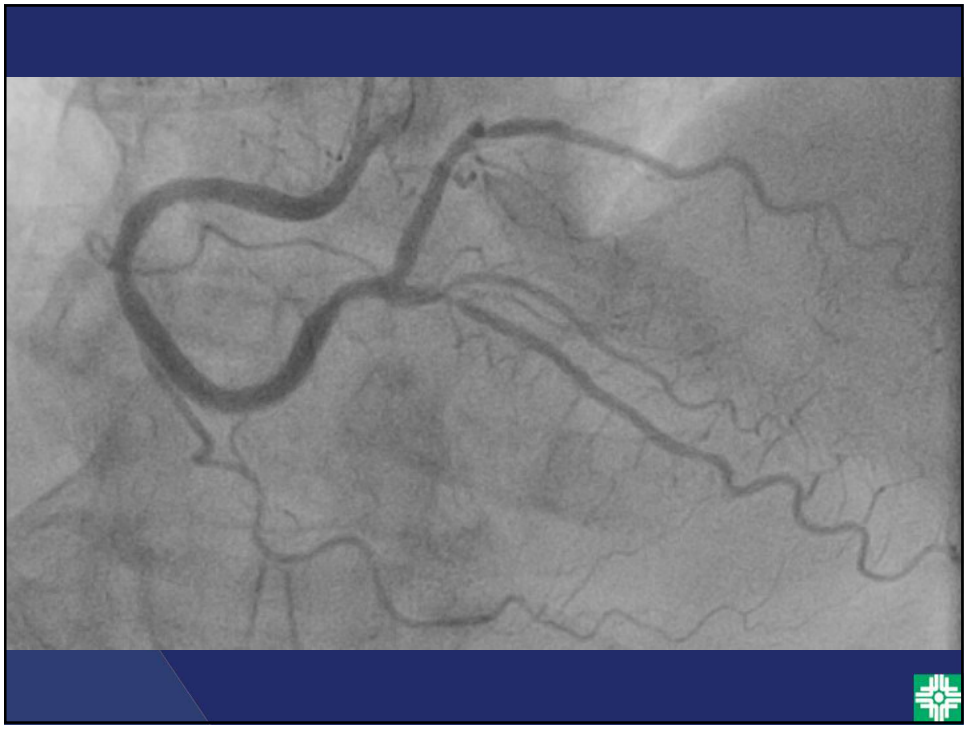
Case

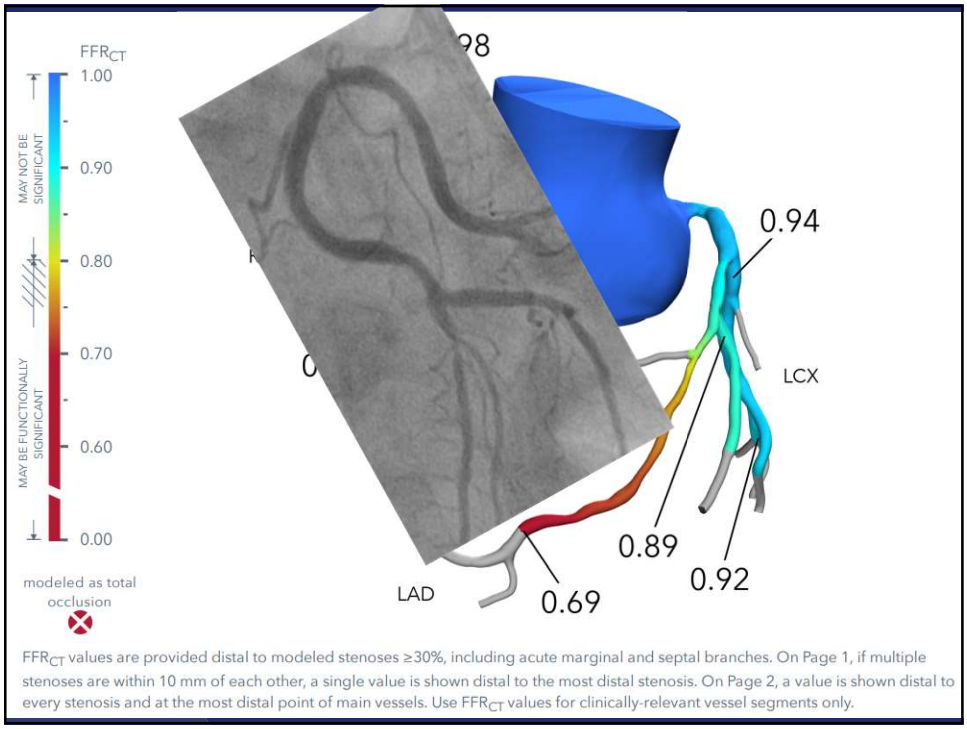
- 70-year-old woman with hypertension and exertional chest pain for the past months with no prior cardiovascular evaluation.
- Amlodipine and metoprolol for hypertension.
- Normal resting TTE
- Next steps?

Next Steps?

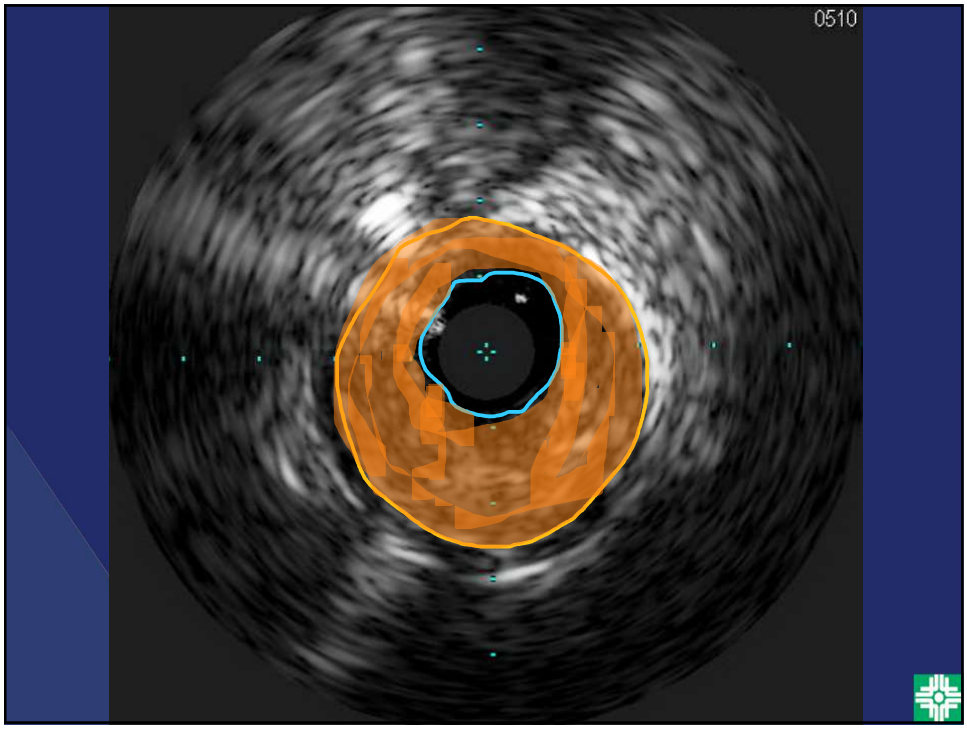
- Non-invasive functional evaluation
  - Stress modality + imaging
  - **Exercise** – Echo/SPECT
  - **Vasodilator** – SPECT/**PET**
  - Dobutamine – Echo
- Non-invasive anatomic evaluation
  - **Coronary CT Angiogram**
  - **FFR-CT (adds functional assessment)**

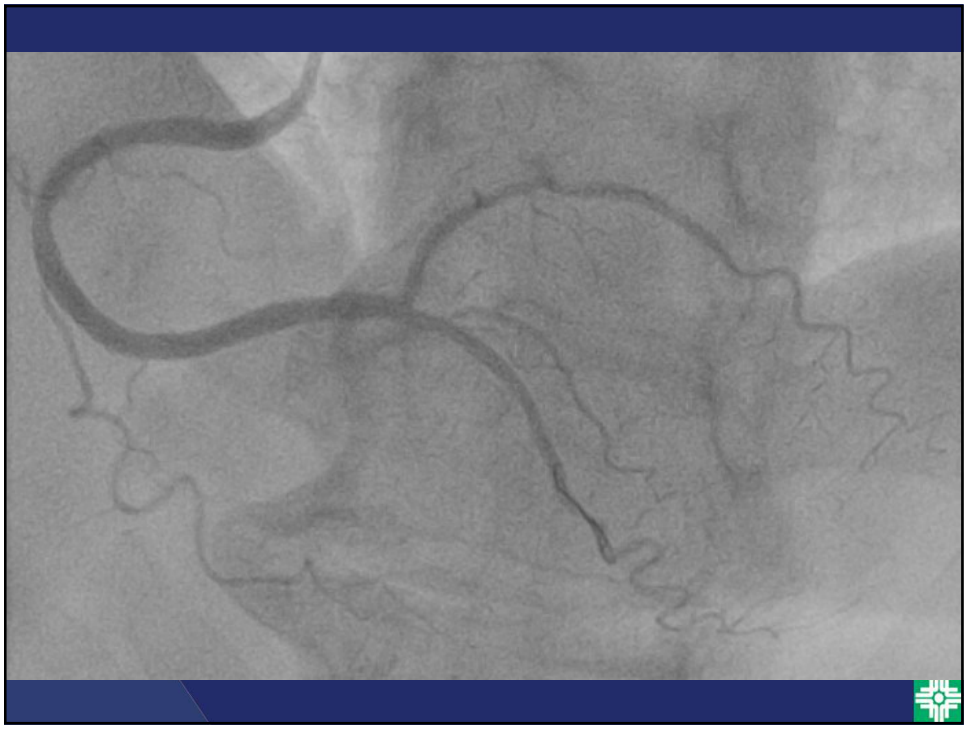

A
5 cm
Phase: 75%
LAO 0 CAU 90
P
Oblique
158%
Average
0.9 mm
W/L: 1000 200
2 of 3
Vessel 10





FFR$_{CT}$ values are provided distal to modeled stenoses ≥30%, including acute marginal and septal branches. On Page 1, if multiple stenoses are within 10 mm of each other, a single value is shown distal to the most distal stenosis. On Page 2, a value is shown distal to every stenosis and at the most distal point of main vessels. Use FFR$_{CT}$ values for clinically-relevant vessel segments only.





Lifestyle Foundations

- Physical activity, reduction in sedentary time
- Smoking cessation and vaccination
- Heart-healthy diet; supplements not recommended (not beneficial)

Lipid Management

- Statins are first-line therapy for all patients
- Add ezetimibe 10mg daily if LDL remains elevated
- PCSK9 inhibitor
  - Intolerant of statin therapy (documented)
  - Hereditary hyperlipidemia
  - LDL>190
- More intensive therapy for higher-risk patients

Medical Therapy

- (Class I) BB, CCB, long-acting nitrate
  - Add second agent
  - Ranolazine
  - SLNG
- Not routinely indicated for lifelong use without
  - Prior MI (<1 year)
  - LVEF ≤ 50%
  - Angina (BB, CCB remain first-line)

Revascularization

- (Class I) **CCD and lifestyle-limiting angina *despite GDMT* --> Revascularize to improve symptoms**
- (Class I) LM/MVD with LVEF≤35% CABG>medical therapy to improve survival.
- (Class I) FFR/iFR if no prior ischemic eval.
- (Class I) CCD, complex disease: HEART TEAM APPROACH

Antiplatelet

- Single antiplatelet therapy standard for most stable patients after 6-12 months from PCI
- Balance ischemic benefit with bleeding risk

Cardiometabolic Therapies

- SGLT2 inhibitors and GLP-1 receptor agonists recommended in select CCD patients
- Benefits extend beyond glycemic control

Follow-up

- **Symptom-driven**
- Routine stress or anatomic testing is not recommended if symptoms have not changed.
- If clinical status changes, escalate testing.

Key Updates: CCD

- **Heart healthy diet and exercise**
- **Cardiac rehabilitation**
- **SGLT2i and GLP-1 agonists**
- Beta-blockers
  - Long-term use NOT unless LVEF≤50%, MI<1yr, angina
  - CCB first-line too
- Statins still first line
- Routine periodic testing without clinical change is NOT recommended

Key Points

- Early ACS recognition and referral are critical
- Primary care is central to long-term CCD management
- Lifestyle and GDMT reduce morbidity and mortality

References

- 2025 ACC/AHA Guideline for the Management of Acute Coronary Syndromes
- 2023 ACC/AHA Guideline for the Management of Chronic Coronary Disease

Thank You