

## Secondary Prevention of a Cardiac Event in Patients with Atherosclerotic Cardiovascular Disease

MVP Health Care, as part of its continuing Quality Improvement Program, has adopted the American Heart Association (AHA) and the American College of Cardiology's Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease (2006 Update). These guidelines are endorsed by the National Heart Lung Blood Institute of the National Institutes of Health.

### Background:

Since the 2001 update of the American Heart Association (AHA)/American College of Cardiology (ACC) consensus statement on secondary prevention advocating risk-reduction therapies for patients with established coronary artery disease (CAD) and other atherosclerotic vascular disease, including peripheral arterial disease, atherosclerotic aortic disease, and carotid artery disease. Aggressive comprehensive risk factor management improves survival, reduces recurrent events and the need for interventional cardiology procedures, and improves quality of life for patients.

### Statistics, Morbidity & Mortality:

Heart disease is the leading cause of death in the United States. Stroke is the third leading cause of death and a leading cause of disability. It is estimated that 1 of 3 American adults has high blood pressure or hypertension. High blood cholesterol is a major risk factor for heart disease, the leading cause of death in the United States. Health Care disparities -In 2004, African-Americans had the highest reported rates of both heart disease and stroke deaths for women and men. Relative to non-Hispanic whites, the excess of heart disease deaths among African-American women was 35% and among African-American men was 28%; the excess of stroke deaths was 37% for women and 55% for men. For 2008, estimated direct costs of \$296.4 billion and indirect costs of \$152.1 billion are projected for all forms of Coronary Vascular Disease.

**Source:** Centers for Disease Control and Prevention (CDC), Division of Heart Disease and Stroke Prevention.

### Key Guideline Messages:

- Blood pressure control: Goal is <140/90 mm Hg or <130/80 mm Hg if patient has diabetes or chronic kidney disease.
- Lipid management: Goal is LDL-C <100 mg/dL. If triglycerides are > 200 mg/dL, non-HDL-C should be <130 mg/dL.
- Physical activity: Goal is 30 minutes, 7 days per week (minimum 5 days per week).

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- Smoking: Goal is complete smoking cessation. No exposure to environmental tobacco smoke.
- Weight management: Goal is body mass index of 18.5 to 24.9 kg/m<sup>2</sup> waist circumference -men <40 inches, women <35 inches.
- Diabetes management: Goal is HbA1c <7%.
- Antiplatelet agents: Start aspirin 75 to 162 mg/d and continue indefinitely in all patients unless contraindicated.
- ACE Inhibitors: Start and continue indefinitely in all patients with left ventricular ejection fraction (LVEF) <40% and in those patients with hypertension, diabetes, or chronic kidney disease, unless contraindicated.
- Angiotensin Receptor Blockers: Use in patients who are intolerant to ACE inhibitors and have heart failure or have had a myocardial infarction with left ventricular ejection fraction <40%. Consider in other patients who are ACE inhibitor intolerant.
- Aldosterone blockade: Use in post-myocardial infarction patients, without significant renal dysfunction or hyperkalemia who are already receiving therapeutic doses of an ACE inhibitor and beta-blocker, have a left ventricular ejection fraction <40%, and have either diabetes or heart failure.
- Beta Blockers: Start and continue indefinitely in all patients who have had myocardial infarction, acute coronary syndrome, or left ventricular dysfunction with or without heart failure symptoms, unless contraindicated.

### Guideline availability:

The guideline may be accessed at either the American Heart Association website ('For Health Care Professionals' icon) at [www.americanheart.org](http://www.americanheart.org), or the American College of Cardiology's website ('Quality and Science' icon) at [www.acc.org](http://www.acc.org).

*This guideline is not intended to replace the role of clinical judgment by the physician in the management of this, or any other disease entity. It is an educational guideline to assist in the delivery of good medical care. **All treatment decisions are ultimately up to the physician.*** Where medication recommendations are made, please refer to each health plan's formulary for coverage considerations.

MVP Health Care updates its clinical guidelines at least every two years. The review process is also initiated when new scientific evidence or national standards are published. Practitioners are alerted via the web site and by written notices from the plan via fax or newsletter. A hard copy of the clinical guideline can be requested by calling the MVP Quality Improvement Department at 1 (800) 777-4793 extension 2602.