IV. TREATMENT

A. Pharmacologic Therapy

Recommendations for Pharmacotherapy to Prevent MI and Death and to Reduce Symptoms

Class I

1. Aspirin in the absence of contraindications. \((\text{Level of Evidence: } A)\)

2. Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI \((\text{Level of Evidence: } A)\) or without prior MI. \((\text{Level of Evidence: } B)\)

3. Angiotensin converting enzyme inhibitor in all patients with CAD* who also have diabetes and/or LV systolic dysfunction. \((\text{Level of Evidence: } A)\)

4. Low-density lipoprotein–lowering therapy in patients with documented or suspected CAD and LDL cholesterol greater than 130 mg per dl, with a target LDL of less than 100 mg per dl. \((\text{Level of Evidence: } A)\)

5. Sublingual nitroglycerin or nitroglycerin spray for the immediate relief of angina. \((\text{Level of Evidence: } B)\)

46. Calcium antagonists† or long-acting nitrates as initial therapy for reduction of symptoms when beta-blockers are contraindicated. \((\text{Level of Evidence: } B)\)

57. Calcium antagonists† or long-acting nitrates in combination with beta-blockers when initial treatment with beta-blockers is not successful. \((\text{Level of Evidence: } B)\)

68. Calcium antagonists† and long-acting nitrates as a substitute for beta-blockers if initial treatment with beta-blockers leads to unacceptable side effects. \((\text{Level of Evidence: } C)\)

Class IIa

1. Clopidogrel when aspirin is absolutely contraindicated. \((\text{Level of Evidence: } B)\)

2. Long-acting nondihydropyridine calcium antagonists† instead of beta-blockers as initial therapy. \((\text{Level of Evidence: } B)\)

3. Lipid-lowering therapy in patients with documented or suspected CAD and LDL cholesterol 100 to 129 mg/dL, with a target LDL of 100 mg/dL. \((\text{Level of Evidence: } B)\)

3. In patients with documented or suspected CAD and LDL cholesterol 100 to 129 mg per dl, several therapeutic options are available: \((\text{Level of Evidence: } B)\)

a. Lifestyle and/or drug therapies to lower LDL to less than 100 mg per dl.

b. Weight reduction and increased physical activity in persons with the metabolic syndrome (see page 74).

c. Institution of treatment of other lipid or nonlipid risk factors; consider use of nicotinic acid or fibric acid for elevated triglycerides or low HDL cholesterol.

4. Angiotensin converting enzyme inhibitor in patients with CAD or other vascular disease. \((\text{Level of Evidence: } B)\)

Class IIb

Low-intensity anticoagulation with warfarin in addition to aspirin. \((\text{Level of Evidence: } B)\)

Class III

1. Dipyridamole. \((\text{Level of Evidence: } B)\)

2. Chelation therapy. \((\text{Level of Evidence: } B)\)

3. Asymptomatic Patients

Recommendations for Pharmacotherapy to Prevent MI and Death in Asymptomatic Patients

Class I

1. Aspirin in the absence of contraindication in patients with prior MI. \((\text{Level of Evidence: } A)\)

2. Beta-blockers as initial therapy in the absence of contraindications contraindications in patients with prior MI. \((\text{Level of Evidence: } B)\)

3. Lipid-lowering therapy in patients with documented CAD and LDL cholesterol greater than 130 mg per dl, with a target LDL of less than 100 mg per dl. \((\text{Level of Evidence: } A)\)
4. ACE inhibitor in patients with CAD who also have diabetes and/or systolic dysfunction. *(Level of Evidence: A)*

Class IIa

1. Aspirin in the absence of contraindications in patients without prior MI. *(Level of Evidence: B)*

2. Beta-blockers as initial therapy in the absence of contraindications in patients without prior MI. *(Level of Evidence: C)*

3. Lipid-lowering therapy in patients with documented CAD and LDL cholesterol of 100 to 129 mg per dl, with a target LDL of 100 mg per dl. *(Level of Evidence: C)*

4. Angiotensin converting enzyme inhibitor in all patients with diabetes who do not have contraindications due to severe renal disease. *(Level of Evidence: B)*