New NICE Guidance on Secondary Prevention of MI

NICE has updated its guidance on the secondary prevention of MI and this month’s bulletin summarises the main messages.

- There are recommendations regarding lifestyle issues such as exercise, smoking cessation, diet and weight control.
- The new guidance re-enforces important advice regarding medicine selection.
- The recommended routine combination of drugs offered to post-MI patients remains unchanged and comprises of: An ACE inhibitor, aspirin, a beta-blocker and a statin (unless contra-indicated).

What are the key recommendations?

a. Cardiac Rehabilitation
This should be offered to all patients, particularly those in groups which may be less likely to access them, such as women, older people, those from lower socio economic groups and people with mental and physical health co-morbidities.

b. Exercise
Patients should be encouraged to be physically active to the point of slight breathlessness for 20 to 30 minutes daily.

c. Smoking cessation
Post-MI patients should be advised to stop and referred to an appropriate smoking cessation service.

d. Diet
NICE identifies the importance of improving the diet and recommends that patients be encouraged to eat a Mediterranean-style diet. They should be advised to eat less meat and to replace butter and cheese with products based on vegetable and fat oils. This diet should include more bread, fruit, vegetables and crucially, two to four portions of oily fish per week.

If, and only if, it proves truly impossible for patients to increase their fish consumption, then consideration may be given to offering treatment with fish oil supplements. This is only recommended if patients have had an MI in the past three months and should not be continued for longer than four years after the event. Fish oil supplements are widely available to buy over the counter in pharmacies at reasonable prices, but increasing dietary intake should be the preferred option.

Large quantities of the prescribable product, Omacor, were returned during the 2005 DUMP campaign. Any decision to add another drug to an already complicated regimen should be made with caution. There is anecdotal evidence that elderly people find the large capsules difficult to swallow.

Supplements containing beta-carotene or anti-oxidants such as Vitamin E or folic acid should not be prescribed. Alcohol intake should be at or under the national recommended safe limits for men and women.

e. Weight control
Overweight and obese people should be encouraged to achieve and maintain a healthy weight.
What about drug treatment?
All patients who have had an MI should be offered an ACE Inhibitor, aspirin, a beta-blocker and a statin.

What are the roles of other treatments?

NICE emphasises that **Angiotensin II receptor antagonists** should never be routinely prescribed unless the patient is truly intolerant of ACE inhibitors. The incidence of ACE inhibitor intolerance in the major trials averaged 10%, so it is less common that we might think. The National Prescribing Centre is preparing a national campaign to reduce sartan usage. I understand it will contain recommendations as to equivalent doses of sartans and ACEIs for different indications.

NICE reminds us that **Clopidogrel** should not be prescribed routinely unless the patient is truly intolerant of aspirin.

- Clopidogrel in combination with aspirin may be used in patients with **non-ST segment elevation acute coronary syndrome**. Combination treatment should be continued for a maximum of twelve months and then the patient switched to aspirin alone.
- After an **ST-segment-elevation MI** patients who have been started on clopidogrel in the acute phase may be given the combination for four weeks only. The clopidogrel should then be stopped and treatment with aspirin alone continued indefinitely.

Clopidogrel is a very expensive drug, the benefits are extremely modest and the risks of major and minor bleeding are high. In view of this strong message in the latest national guidance, clinicians are urged to review all secondary prevention patients on aspirin and clopidogrel and to agree a stop date for clopidogrel.

For patients truly intolerant of aspirin and clopidogrel moderate-intensity **Warfarin** (INR 2-3) for up to four years or longer is now considered an option. A combination of clopidogrel and warfarin is **not recommended**.

Post-MI patients with heart failure and left ventricular systolic dysfunction should be offered **Spironolactone** within three to fourteen days of an acute MI. This should ideally be added in after the ACE inhibitor.

**A Calcium Channel Blocker** is not routinely recommended for secondary prevention, nor is **Nicorandil**.

In summary

- Changes to lifestyle are key in secondary prevention of MI.
- Increasing consumption of fish is a cornerstone of the dietary advice. Fish oil supplements should only be prescribed if this is truly impossible.
- NICE states that ACEIs should be used first-line for all post-MI patients and sartans reserved for patients truly intolerant of ACEIs.
- Clopidogrel should be used cautiously and for a maximum of 12 months in post Non-ST-segment-elevation patients and for just 1 month in post ST-segment-elevation patients.
- Recommended routine drug treatment is unchanged and comprises : Aspirin, A Beta-blocker, an ACE Inhibitor and a Statin.

The full guidance is available at [www.nice.org.uk](http://www.nice.org.uk).

"Prescribing" bulletins are now published on the States of Guernsey Website:

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