# 3. Post MI Therapy

1. **Aspirin:**
   a. 81 mg qd
2. **ACE Inhibition:**
   a. Start within 24 hours of MI (ISIS-4, GISSI-3, HOPE)
   b. Reduces risk of severe CHF, recurrent MI, stroke, diabetes
3. **ß-blockers:**
   a. Reduces mortality of post-MI patients and effective in heart failure
   b. Start or continue oral after IV metoprolol to give resting heart rate (<70)
   c. Atenolol 25-50-100mg qd as tolerated,
      or Metoprolol-XL 25-50 mg qd, if creatinine > 1.8 mg/dl or age > 80 years
4. **Cholesterol/Lipid Reduction:**
   a. Relative risk reduction was ~30% for mortality and serious cardiovascular events
   b. Goal: LDL< 70 mg/dl, HDL> 40 mg/dl, Triglycerides < 150 mg/dl, Non HDL Cholesterol < 100 mg/dl.
   c. First line: Simvastatin 40 mg qhs (some prefer Atorvastatin), Second line Vytorin 10/40 mg qhs
5. **Clopidogrel/PLAVIX:** 75 mg qd possibly for 12 months, 300-600 mg loading dose at time of PTCA.

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**Others:**

1. **Smoking Cessation:** Bupropion/ZYBAN: 150mg qd x 7 days, then stop smoking the bid x 7-12 weeks
   Varenicline/CHANTIX 0.5 mg qd x 3 days, then 0.5 mg bid x 4 days, then 1 mg bid
2. **Aldosterone inhibitor:** Eplerenone 25 mg qd, increase to 50 mg after 4 weeks for EF≤ 40%
   or Spironolactone 12.5 to 25 mg qd
3. **Warfarin** (COUMADIN)
   a. Warfarin (INR 2.0 to 2.5) + Aspirin low dose better to prevent recurrent MI (WARIS2, NEJM 9/02)
   b. Warfarin should be instituted in most patients with large anterior MI x 3 months
   c. Warfarin should be used in patients with ventricular aneurysm and clots
4. **Anti-arrhythmics**
   a. Long term increased incidence of fatal and non-fatal events with Ia and Ic agents (CAST-1989)
   b. Amiodarone or Dofetilide is generally the preferred agent, for atrial fibrillation control
   c. D-sotalol is not recommended for patients with reduced LV EF post-MI
5. **AICD** (Automatic Implantable Cardioverter Defibrillator) Device
   a. Consider for EF < 40% and symptomatic or asymptomatic VT
      MUTTI Study NEJM 341(25):1882-1890, December 16, 1999
   b. This is VF/VT not related to acute infarction (<6 weeks) or metabolic abnormality
   c. Cardiac arrest or sustained VT with defibrillation
   d. CABG Patch Trial and the Defibrillator in Acute Myocardial Infarction Trial (DINAMIT)--found prophylactic implantation of an ICD did not reduce the risk of death
   e. Life expectancy >1 year

**And Others:**

1. **Calcium Channel Blockers**
   a. No clear benefit of this class for routine use
   b. Mostly Diltiazem useful to slow rate for patients intolerant of ß-blockers
   c. Short acting Dihydropyridines contraindicated due to reflex tachycardia and steal syndromes
   d. Long acting Dihydropyridines may be useful in severe hypertension (Nifepidine-XL/CC/ER)
2. **Diet** - **Ideal Weight**: Waist/Hip Ratio 0.9 Males, 0.8 females. BMI < 26.
3. **Exercise:** 30 minutes almost every day, walking
4. **Glucose:** Sulfonoureas and Insulin promote atherosclerosis? Metformin and Pioglitazone
5. **Symptom Control:** Sublingual-PRN Nitrates, Patches and Ca channel blocker
6. **Refractory Angina** Ranolazine (RANEXA) Reduces Sodium Calcium Exchange
7. **Alcohol** Consuming 1-2 drinks of per day may reduces angina and MI (modest amount not harmful)
8. **Social Isolation** Adversely affects prognosis