REBELLIOUS MEDIC · CARDIOLOGY ALGORITHM SERIES

Chronic Coronary Disease

Diagnostic testing, foundational GDMT, antianginal therapy, revascularization strategy, and antiplatelet therapy for CCD.

2023 AHA/ACC/ACCP/ASPC/NLA/PCNA
Chronic Coronary Disease Guideline
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COR — I · Recommended | IIa · Reasonable | IIb · May Consider | III · No Benefit / Harm

1 Diagnostic Testing & Risk Stratification

All patients with established CCD — reassess at every visit

COR / LOE	
I B-NR	New/worsened symptoms **despite optimized GDMT**: stress PET/SPECT MPI, stress CMR, or stress echo recommended to detect ischemia, estimate MACE risk, and guide therapy. **PET preferred over SPECT** when available (IIa).
I B-R	Same setting — **invasive coronary angiography (ICA)** recommended for guiding therapeutic decisions to improve anginal symptoms.
I A	Newly **reduced LV systolic function, clinical HF, or both**: ICA recommended to assess coronary anatomy and guide revascularization.
III NB/A	ICA **not routinely recommended** for risk stratification without LV dysfunction, HF, refractory chest pain, or noninvasive testing suggesting significant left main disease. **Routine periodic retesting** without a change in status is not recommended.
I B-NR	Integrate testing with demographic, social, and clinical variables to classify annual MACE risk as **low (<1%) · intermediate (1–3%) · high (>3%)**. Testing alone is insufficient to risk-stratify.

2 Foundational GDMT — Start in Every Patient

Optimization of GDMT is recommended to reduce MACE (I, A)

LIPID-LOWERING

COR / LOE	
I A	**High-intensity statin**, goal ≥50% LDL-C reduction. If not tolerated, moderate-intensity statin (goal 30–49%).
IIa B-R/A	If **very-high-risk** and LDL-C ≥70 on max-tolerated statin: add **ezetimibe**, then **PCSK9 mAb**. Bempedoic acid/inclisiran reasonable (IIb) if insufficient.
IIb B-R	Persistent fasting TG 150–499 on max statin: **icosapent ethyl** may be considered.

BLOOD PRESSURE

COR / LOE	
I B-R	Target **<130/<80 mmHg**. First-line: ACE-I, ARB, or beta blocker for compelling indications; add CCB/thiazide/MRA as needed.

ANTIPLATELET (NO OAC INDICATION)

COR / LOE	
I A	**Aspirin 81 mg (75–100 mg)** monotherapy. Clopidogrel not additive without recent ACS/PCI indication (III: NB, A).

SGLT2I / GLP-1 RA

COR / LOE	
I A	**T2DM:** SGLT2i or GLP-1 RA with proven CV benefit recommended to reduce MACE. **HFrEF (LVEF ≤40%):** SGLT2i recommended regardless of diabetes status.

LIFESTYLE & FOLLOW-UP

COR / LOE	
I C-LD	Nutrition, cardiac rehab, weight management, tobacco cessation, immunizations, mental-health screening for all. **Follow-up ≥ annually.**

3 Antianginal Therapy Ladder

For angina or an anginal equivalent

COR / LOE	
I B-R	**Step 1 —** Beta blocker **or** CCB **or** long-acting nitrate (either class as first-line antianginal).
	↓ symptoms persist
I B-R	**Step 2 —** Add a second antianginal agent from a **different** class.
	↓ symptoms persist
I B-R	**Step 3 —** Add **ranolazine**. Sublingual nitroglycerin recommended for immediate short-term relief (I, B-NR).
	↓ refractory, no other options
IIb B-R	Enhanced external counterpulsation (EECP) may be considered for symptom relief.

2023 update — beta blockers: Not beneficial for MACE reduction without LVEF ≤50%, prior MI (<1 yr), or another primary indication (III: NB). Reassess long-term (>1 yr) use post-MI if no current LVEF ≤50%, angina, arrhythmia, or hypertension (IIb). Avoid adding **ivabradine** with normal LV function — potentially harmful (III: Harm).

4 Revascularization — Goals, Indications & PCI vs. CABG

Symptom relief is the primary driver; survival benefit is anatomy/LV-function specific

COR / LOE	
I A	Lifestyle-limiting angina **despite GDMT** with significant, amenable stenosis → revascularization to improve symptoms.
I B-R	Left main **or** multivessel disease with **severe LV dysfunction (LVEF ≤35%)** → CABG + medical therapy over medical therapy alone to improve survival.
IIa B-R	Multivessel CAD appropriate for either CABG or PCI → revascularization reasonable to lower risk of spontaneous MI, urgent revascularization, or cardiac death.
IIa B-NR	Significant left main stenosis where PCI can achieve **equivalent** revascularization to CABG → PCI reasonable to improve survival.
I A	Angiographically intermediate stenosis, angina/equivalent, no prior ischemia evaluation → **FFR or iFR** recommended before PCI.
I B-NR	Complex 3-vessel disease or unclear optimal strategy → multidisciplinary **Heart Team** approach recommended.

COR / LOE	CLINICAL SCENARIO	PREFERRED STRATEGY
I · B-R	Left main involvement with high-complexity CAD	**CABG** preferred over PCI to improve survival
IIa · B-R	Multivessel, complex/diffuse CAD (e.g., SYNTAX >33)	**CABG** reasonable over PCI to improve survival
I · A	Diabetes + multivessel CAD involving LAD, CABG candidate	**CABG** (LIMA→LAD) preferred to reduce mortality & repeat revasc.
IIb · B-R	Diabetes + left main, low/intermediate complexity (SYNTAX ≤33)	**PCI** may be considered as an alternative to CABG
IIa · B-NR	Appropriate for revascularization but poor surgical candidate	**PCI** reasonable over CABG for symptoms & MACE

5 Antiplatelet Therapy After Revascularization

POST-PCI (NO OAC INDICATION)

COR / LOE	
I A	**DAPT** (aspirin + clopidogrel) × 6 months → single antiplatelet therapy (SAPT) to reduce MACE and bleeding.
IIa A	DES with 1–3 month DAPT completed: **P2Y12 monotherapy** ≥12 months reasonable to reduce bleeding risk.
IIb A	Prior MI + low bleeding risk: **extended DAPT** up to 3 years may be reasonable to reduce MACE.
IIa B-R	PPI co-therapy with DAPT can be effective to reduce GI bleeding risk.

OAC INDICATED (E.G., CONCOMITANT AF)

COR / LOE	
I B-R	Elective PCI + OAC required: DAPT for 1–4 weeks → **clopidogrel alone** to 6 months, in addition to DOAC.
IIb B-R	Low atherothrombotic risk: discontinue aspirin, continue **DOAC monotherapy** alone ~1 year after PCI to reduce bleeding.

AVOID

COR / LOE	
III Harm	**Vorapaxar** or **prasugrel** with prior stroke/TIA/ICH; chronic **NSAIDs** — increased bleeding/CV risk.

Virani SS, Newby LK, Beckman JA, et al. 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA Guideline for the Management of Patients With Chronic Coronary Disease. *J Am Coll Cardiol.* 2023;82(9):833–955.