KISS: Management Post-MI

Based on BJGP2018;68:151 & NICE TA420 & CKS Antiplatelets Sept 2018

Non-pharmacological therapy:

- **Cardiac Rehabilitation -** for all patients, ideally within 10 days of discharge from hospital
- **Lifestyle** - Mediterranean diet; Stop smoking; Weight loss; Moderate alcohol; Exercise

Pharmacological therapy:

- There is no 'one-size-fits-all' drug regime due to range of presentations (STEMI vs NSTEMI), timing and type of reperfusion (PCI vs CABG), and comorbidites (AF, heart failure, hypertension) - decisions should be made in conjunction with local guidelines/cardiologists
- **However, after MI all patients should receive (unless contraindications)** antiplatelets plus ACEi, statin, beta blocker; aldosterone antagonists may be considered if LV dysfunction
- **Antiplatelets & dual antiplatelet therapy (DAPT):**
    - Aspirin should be continued lifelong, or clopidogrel 75mg if they are aspirin intolerant
    - *DAPT is indicated in all patients following STEMI and NSTEMI*
        - Aspirin 75mg + Ticagrelor 90mg bd is the preferred combination for 12 months
            - If the bleeding risk is high, DAPT may be shortened e.g. to 6 months
            - If the bleeding risk is low and higher CV risk DAPT may be extended after a year with a lower dose of ticagrelor 60mg bd for up to 3 years
        - DAPT with aspirin + clopidogrel preferred if the patient cannot receive ticagrelor
        - If the patient also needs anticoagulation (e.g. atrial fibrillation or venous thromboembolism), a specialist led individualised regimen is required
        - Some high risk patients may be offered aspirin +/- clopidogrel + low dose rivaroxaban 2.5mg bd NICE TA335
        - Co-prescribe PPI if high risk for GI complications (older age esp >70, PH gastroduodenal ulcer/perforation or GI bleed, Helicobacter infection, use of other high risk drugs (anticoagulants, corticosteroids, SSRIs, NSAIDs, nicorandil)
- **Statins:**
    - Intensive treatment with **Atorvastatin 80mg** indefinitely NICE 2014
    - Consider lower 40mg dose if high risk of adverse events or interactions; use 20mg atorvastatin initially in patients with CKD (risk of kidney injury with high dose)
- **ACE inhibitor:**
    - Titrate to *maximum tolerated dose*, and continue long-term; ARB if ACEi not tolerated
- **Beta-blocker:**
    - Start as soon as haemodynamically stable and titrate to maximum tolerated dose
    - If LV dysfunction continue indefinitely; If normal LVF consider stopping at 1 year

Getting back to normal life:

- **Sexual intercourse** - can be resumed once patients comfortable to do so (often ~1 month); if erectile dysfunction PDE5 inhibitors can be used 6 months post-MI (C/I if on nitrates)
- **Driving** - Group 1 drivers do not need to inform DVLA but must not drive for 1 week if had successful PCI or 4 weeks if not had PCI, LV ejection fraction ≤40% or further PCI planned
- **Flying** - CAA advise if complication-free patients can fly 10 days post-MI; if any complications should not fly without advice from cardiologist; patients should inform travel operator/airline