SECONDARY PREVENTION PATTERNS IN PATIENTS WITH PRE-EXISTING CORONARY ARTERY DISEASE ADMITTED WITH MYOCARDIAL INFARCTIONS
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BACKGROUND: In individuals with pre-existing coronary artery disease (CAD), secondary prevention reduces risk of major adverse cardiac events such as death and myocardial infarctions (MI). Smoking cessation, antiplatelet therapy, lipid lowering therapy, beta-blockers and ACE inhibitors or angiotensin receptor blockers (ARB) all form secondary prevention.

OBJECTIVE: To determine secondary prevention patterns in individuals with pre-existing CAD admitted into UMMC with an MI.

METHODS: Retrospective, observational study of secondary prevention in patients with pre-existing CAD admitted with STEMI or NSTEMI in UMMC from September 2016 to January 2017.

RESULTS: 86 patients (62 males, 24 females) with a mean age of 64 years old were included. There were 20 (23%) STEMI and 66 (77%) NSTEMI cases. 20 (23%) patients had previous MI, 12 (14%) had previous CABG, 40 (47%) had previous angioplasty and 14 (16%) had non-revascularised CAD diagnosed on previous angiograms. 28 (33%) patients were on dual antiplatelet therapy, 35 (41%) were on aspirin monotherapy, 8 (9%) were on clopidogrel monotherapy and 15 (17%) were not on any antiplatelets. 66 (77%) patients were on statin therapy, 1 (1%) on ezetimibe and 19 (22%) were not on any lipid lowering therapy. Only 47 (55%) were on beta blockers and 48 (56%) were on either an ACE inhibitor or an ARB. 26 (30%) of patients were still active smokers.

CONCLUSION: Despite a small cohort, it is already evident that there is suboptimal secondary prevention among patients with pre-existing CAD. Reasons for this may include poor physician prescribing patterns and patient compliance. Reduction of risk of developing myocardial infarction in this high-risk group requires effective prescribing and encouraging patient compliance towards evidence based pharmacological therapy and lifestyle modification such as smoking cessation, weight loss and exercise. Physicians and patients should work together to achieve realistic risk-lowering targets such as ideal bodyweight, LDL and HbA1c levels.