

Ischaemic heart disease

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Patients with angina that is not well controlled should be investigated further by a cardiologist. The indications for coronary revascularisation in patients awaiting surgery are the same as at any other time. Pharmacological protection is indicated. - Patients established on β -blockers and statins should have their medication continued perioperatively. Initiating statins preoperatively should be considered if not already prescribed. Most long-term cardiac medications should be continued over the perioperative period. Angiotensin-converting enzyme (ACE) inhibitors and receptor blockers are often omitted 24 hours prior to surgery to prevent intraoperative hypotension, and restarted the next day for most surgery. - In patients with IHD the cardiac and coronary reserve can be evaluated using a stress test (stress ECG, stress echo, myocardial scintigraphy). The tests have a high negative predictive value but a relatively low positive predictive value. If the test is negative, the patient is unlikely to have IHD; conversely, if it is positive the chances of the patient actually having IHD are not necessarily very high, but there is a need for further investigation such as coronary angiography or cardiac computed tomography. Recently, measurement of the coronary fractional flow reserve during coronary angiography using a pressure wire has made it possible to identify coronary lesions that have the largest impact on myocardial perfusion. After a proven myocardial infarction (MI) (Figure 21.4) elective surgery should be postponed for 3–6 months to reduce the risk of perioperative reinfarction. Ischaemic changes can be seen on ECG even if the patient is not symptomatic (silent ischaemia/silent MI). These merit discussion with a cardiologist.

V4 V1 V5 V2 V6 V3 Figure 21.4 Preoperative electrocardiogram of a patient who complained of chest pain the previous day, showing recent transmural anterior myocardial infarction with Q waves and ST elevation.

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