# Ischaemic heart disease

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Patients with angina that is not well controlled should be inves - tigated 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 e ven 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 com plained of chest pain the previous day, showing recent transmural anterior myocardial infarction with Q waves and ST elevation.

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