NHS
South East London

Optimising Prescribing for Chronic Stable Angina

The guidance does NOT override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Angina is the main symptom of myocardial ischaemia and is usually caused by atherosclerotic obstructive coronary artery disease restricting blood flow and therefore oxygen delivery to the heart muscle. The aim of management is to stop or minimise symptoms, and to improve quality of life and long-term morbidity and mortality. Management options include lifestyle advice, drug treatment and revascularisation using percutaneous or surgical techniques.

Overarching Principles of Management

- **Explore and address issues according to the person's needs**, which may include:
  - Self-management skills such as pacing their activities and goal setting
  - Concerns about the impact of stress, anxiety or depression on angina
  - Advice about physical exertion including sexual activity
- **Offer a short-acting nitrate for preventing and treating episodes of angina**
- **Offer drug treatment for the initial management of stable angina**

1) **anti-anginal drugs** (see flow diagram on page 2)
   - Offer either a beta blocker or a rate controlling calcium channel blocker (CCB) as first-line treatment for stable angina.
   - Do not routinely offer other anti-anginal drugs as first-line treatment for stable angina (eg. non rate controlling CCB, long-acting nitrate, nicorandil, ivabradine, ranolazine)
   - Review the person's response to treatment, including any side effects, 2–4 weeks after starting or changing drug treatment

2) **secondary prevention of cardiovascular disease**
   - aspirin 75 mg daily for people with stable angina. Take into account the risk of bleeding and comorbidities.
   - statins (in line with South London Lipid Management: Medicines Optimisation Pathways)
   - treatment for high blood pressure (in line with CESEL South London Hypertension guidance)

Consider angiotensin-converting enzyme (ACE) inhibitors for people with stable angina and diabetes. Offer or continue ACE inhibitors for other conditions, in line with relevant NICE guidance.

Do not:

- Exclude people from treatment based on their age alone
- Investigate or treat symptoms differently based on gender or ethnic group
- Offer vitamins or fish oil. Inform people there is no evidence that they help stable angina
- Offer transcutaneous electrical nerve stimulation (TENS), enhanced external counterpulsation (EECP) or acupuncture to manage stable angina

- **Consider revascularisation** (coronary artery bypass graft [CABG] or percutaneous coronary intervention [PCI]) for people with stable angina whose symptoms are not satisfactorily controlled with optimal medical treatment

For more information on managing stable angina, including the advice, information and support which should be offered to patients see: https://www.nice.org.uk/guidance/cg126

For NICE guidance on improving Medicines Adherence see: http://www.nice.org.uk/guidance/CG76

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South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System: NHS South East London (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust

NHS South East London

Medical therapy for chronic stable angina

Therapies to prevent episodes of angina
FIRST LINE: Offer a beta-blocker, such as bisoprolol 5mg daily*
Aim to increase dose to achieve a heart rate between 50-60 beats per minute (bpm)
***Note:** A lower starting dose maybe appropriate in specific patient groups, such as the elderly or those with hypotension*

Therapies to improve prognosis:
- Start aspirin 75mg daily
- Start a statin and manage lipids in line with South London Lipid Management: Medicines Optimisation Pathways
- Manage blood pressure in line with CESEL South East London Hypertension Guidance

Provide sublingual GTN for use as required

If beta-blocker is contraindicated or not tolerated consider a rate-controlling calcium channel blocker (diltiazem or verapamil)

If additional anti-anginal therapy is required add a dihydropyridine calcium channel blocker, such as amlodipine daily

If both beta-blockers and calcium channel blockers are contraindicated or not tolerated consider monotherapy with:
- a long-acting nitrate (e.g isosorbide mononitrate/dinitrate) or
- nicorandil or
- ivabradine** or
- ranolazine***

If rate-controlling calcium channel blocker is contraindicated or not tolerated consider a dihydropyridine calcium channel blocker (amlodipine)

If symptoms are not satisfactorily controlled, consider adding a long-acting nitrate, nicorandil or ranolazine*

If dihydropyridine calcium channel blocker is contraindicated or not tolerated consider adding a long-acting nitrate, nicorandil, ivabradine** or ranolazine***

If symptoms are not satisfactorily controlled, consider adding a long-acting nitrate, nicorandil, ivabradine** or ranolazine***

If symptoms are not adequately controlled, consider referral for revascularisation; an additional anti-anginal may be added whilst awaiting cardiology review

****Ivabradine:** (Amb2) may be useful in symptomatic patients where heart rate remains greater than 60bpm despite optimal dose of beta-blocker or rate controlling calcium channel blocker; or where these rate controlling agents are contra-indicated or not tolerated

*****Ranolazine:** (Amb2) may be useful in patients where the use of other options is limited by bradycardia or hypotension

Deprescribing- see notes overleaf

*The Medicines and Healthcare products Regulatory Agency (**MHRA**) has issued **drug safety updates** for **ivabradine** and **nicorandil- see links overleaf***

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Deprescribing

In fit or robust older adults, management of cardiovascular and other modifiable risk factors should be considered, taking into account clinical priorities and individual circumstances.

In those with severe frailty (CFS Scale 7-9), limited life expectancy or those approaching end of life, clinicians should carefully weigh the potential benefits of ongoing medication against the risks of harm. Treatment should be aligned with the patient's goals and priorities and deprescribing considered where appropriate through a shared decision-making process involving the patient and/or carer. Anti-anginal therapies, including nitrates, nicorandil, and ranolazine, have not been shown to reduce cardiovascular mortality or the incidence of myocardial infarction (STOPPFrail v2). In this population, cautious dose reduction and discontinuation should be considered, as deprescribing is often safe and well tolerated.

When and how to deprescribe (A-guide-to-deprescribing-long-acting-nitrates.pdf)

- In patients with no reported anginal symptoms in the preceding 12 months and no objective or documented evidence of coronary artery disease (STOPFrail v2).
- When the risks or adverse effects of treatment outweigh potential benefits, for example long-acting nitrates increase the risk of orthostatic hypotension, falls, and fractures.
- Polypharmacy and high pill burden, which may increase drug interactions, adversely affect quality of life and medication adherence.
- When medicines are no longer clinically indicated or are no longer desired by the patient e.g nitrates after successful revascularisation, immobility, or at the patient's request.
- Deprescribing anti-anginal medications, including beta-blockers, should be undertaken by tapering gradually with close clinical monitoring (including chest pain and heart rate) to minimise the risk of rebound symptoms or worsening angina.

MHRA advice for healthcare professionals

Prescribing of ivabradine in stable angina Ivabradine (Procoralan) in the symptomatic treatment of angina: risk of cardiac side effects - GOV.UK

Ivabradine should only be initiated if the resting heart rate is at least 70 bpm
Do not prescribe ivabradine with other medicines that cause bradycardia, such as verapamil, diltiazem, or strong CYP3A4 inhibitors.
Monitor patients regularly for atrial fibrillation (AF). If AF occurs, carefully reconsider whether the benefits of continuing ivabradine treatment outweigh the risks and consider stopping ivabradine if there is no or only limited symptom improvement after 3 months.

Prescribing of nicorandil in stable angina Nicorandil: risk of gastrointestinal ulceration - GOV.UK

The use of nicorandil for the treatment of stable angina should be restricted to second-line therapy where there is a contraindication or intolerance to beta blockers or calcium channel blockers. MHRA advice is to stop nicorandil treatment if ulceration occurs - consider the need for alternative treatment or specialist advice if angina symptoms worsen.

References

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5. Mearns S. Primary Health Tasmania and the Deprescribing Project Advisory Group A guide to deprescribing Long- Acting Nitrates Accessed at *[https://www.primaryhealthtas.com.au/wp-content/uploads/2023/03/A-guide-to-deprescribing-long-acting-nitrates.pdf]* 18.12.2025
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