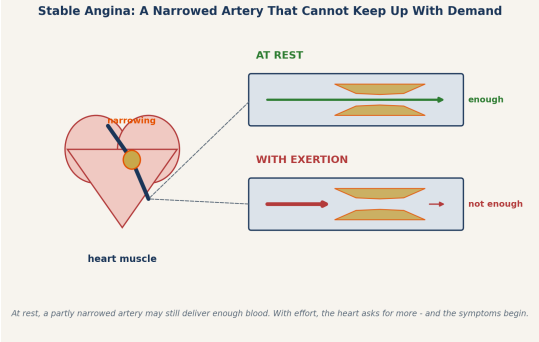
Stable Angina

Chronic Coronary Disease - the Predictable Chest Discomfort of Effort

If your chest discomfort is new, lasts more than a few minutes, or comes at rest - call 911.



Online: https://go.riasalimd.com/stable-angina-guide

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Names & Terms You Will Hear

Term	Meaning
Stable angina	Chest pressure, tightness, or shortness of breath that comes with effort and goes away with rest. The pattern stays the same over weeks to months.
Angina pectoris	The medical name for chest discomfort caused by a narrowed heart artery. 'Pectoris' means 'of the chest'.
Chronic coronary disease (CCD)	The umbrella name in the 2023 guideline for long-standing narrowing of the heart arteries - includes stable angina.
Chronic stable angina	Another name for the same thing. 'Chronic' means it has been there for at least a few weeks without getting worse.
Exertional angina	Angina that is brought on by physical effort. The most common pattern.
Microvascular angina	Angina from very small heart arteries that scans cannot see well. More common in women. Same care plan in most cases.
Vasospastic / Prinzmetal angina	Angina from a sudden tightening (spasm) of a heart artery, often at rest. Has a separate treatment focus - see our Coronary Vasospasm guide.
Atypical angina	Symptoms that do not match the classic 'chest pressure with effort' pattern - for example, shortness of breath, jaw discomfort, or unusual tiredness.
Angina equivalent	Symptoms other than chest discomfort that mean the same thing - shortness of breath, jaw or arm discomfort, or unusual tiredness with effort.
Silent ischemia	Heart-artery trouble found on tests in a patient who does not feel angina. More common in people with diabetes.
Unstable angina	Angina that is new, happens at rest, or is getting worse fast. This is part of the heart-attack family - call 911. See our Heart Attack (ACS) guide.

Term	Meaning
CCS class (I to IV)	A way doctors grade angina by how much effort it takes to trigger it. Class I is heavy effort only; class IV is at rest.
Ischemia	Not enough blood flow to a tissue. In the heart, ischemia is what causes angina.
Revascularization	Opening or bypassing a narrowed artery - usually with a stent (PCI) or bypass surgery (CABG).
Optimal medical therapy (OMT)	The full medicine + lifestyle plan for stable disease. For many patients, OMT works as well as a stent for staying alive.

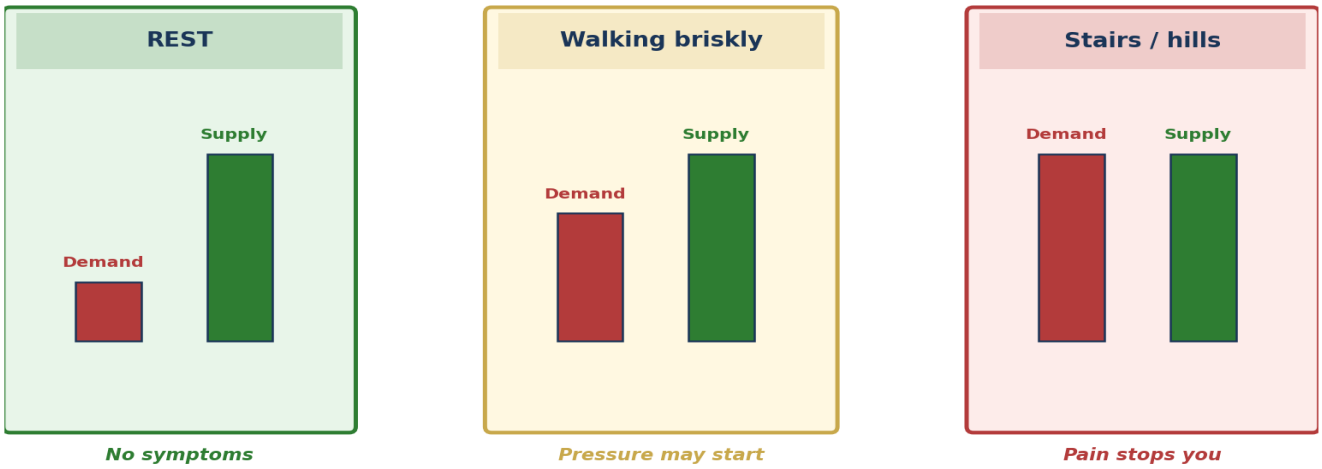
Call 911 now if your chest discomfort is new for you, lasts more than a few minutes, happens at rest, or comes with shortness of breath, a cold sweat, nausea, or pain spreading to the arm, jaw, neck, or back. **Do not drive yourself.** This is the pattern of a heart attack, not stable angina.

What makes angina 'stable.' The pattern stays the same: the same trigger (a flight of stairs, a brisk walk, a stressful moment), the same intensity, and the same relief with rest in a few minutes. A change in pattern is the warning sign that the disease may be progressing.

Stable Angina?

- Stable angina is chest pressure, tightness, or shortness of breath that comes with effort or stress and goes away with rest.
- It happens because a heart artery is narrowed - usually by plaque buildup - and cannot deliver enough blood when the heart is working hard.
- The key word is 'stable.' The pattern stays the same over weeks to months: same trigger, same intensity, same relief with rest.
- Some people feel discomfort somewhere other than the chest - in the jaw, neck, shoulder, upper back, or upper belly. These count.
- Some people have no chest pain at all - just shortness of breath, unusual tiredness, or nausea with effort. These count too.
- Stable angina is part of a bigger disease called coronary artery disease. It is a warning sign that the same artery could one day cause a heart attack.

Why Angina Comes With Effort: Demand Rises, Supply Is Capped



At rest, supply meets demand. As effort rises, the heart needs more blood - but the narrowing caps how much can flow through. Symptoms begin when demand exceeds the ceiling.

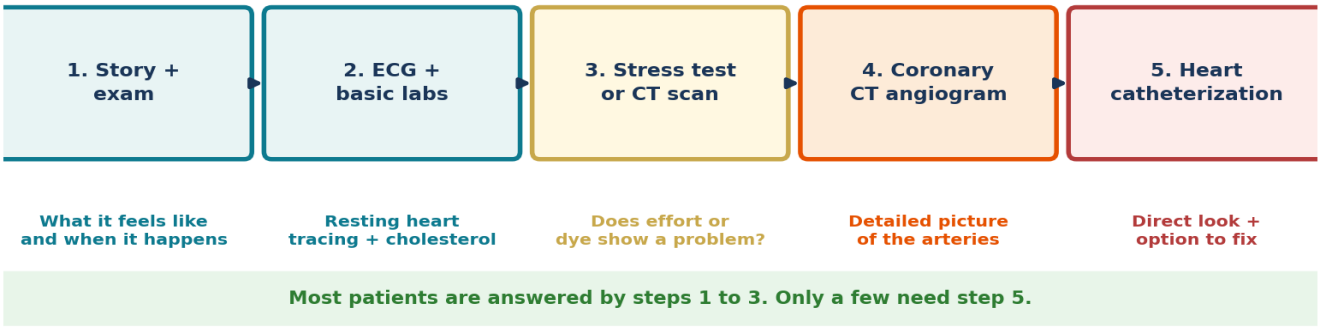
Typical, Atypical, and Silent - The Many Faces of Angina

- **Typical angina** has three features - chest pressure or tightness, brought on by effort or stress, and eased by rest or nitroglycerin within minutes.
- **Atypical angina** has only two of those three features. A common pattern: pressure that does not come with effort, or effort symptoms that do not feel like chest pressure.
- **Angina equivalents** are symptoms other than chest discomfort that mean the same thing - shortness of breath, jaw or arm discomfort, or unusual tiredness with effort.
- **Silent ischemia** is heart-artery trouble found on tests in a patient who does not feel angina. More common in people with diabetes, older adults, and after a previous heart attack.
- **Microvascular angina** comes from very small arteries that scans cannot see well. More common in women. Same care plan in most cases - lifestyle, statin, and antianginal medicines.
- **Vasospastic angina** comes from a sudden tightening (spasm) of a heart artery, often at rest or at night. It has a different treatment focus - see our Coronary Vasospasm guide.

Why It Matters

- Angina tells us a heart artery is narrowed and not getting enough blood during effort.
- Knowing the pattern - what brings it on, how long it lasts, what makes it better - tells the care team how serious it is.
- A change in pattern matters. New angina, angina at rest, or angina that lasts longer than usual is a red flag - call 911.
- Stable angina does not always lead to a heart attack, but the same artery problem causes both. Treating the disease lowers the chance of a heart attack and stroke.
- For most people with stable disease, medicines plus lifestyle work as well as a stent for staying alive. Stents help when symptoms continue or anatomy demands it.
- Cardiac rehab and a daily medicine plan are the parts that pay off for years - not a one-time procedure.

How the Diagnosis Is Sorted Out - From History to Cath Lab



The diagnosis is usually answered by the first three steps. Step 5 (heart catheter) is needed only when the question is not yet answered or a stent is being considered.

What the Care Team Looks For - the First Visit

- We start with your story. What does it feel like? What triggers it? How long does it last? What eases it? This alone answers most of the question.
- A short physical exam - blood pressure, heart and lung sounds, leg pulses - tells us about other artery problems.
- An ECG (heart tracing) at rest is checked for past damage or current strain.
- Blood tests measure cholesterol, blood sugar, kidney function, and thyroid - all of which change the plan.
- From there, a stress test or a coronary CT angiogram is often the next step. The choice depends on your risk and what we want to learn.
- A heart catheter (angiogram) comes later, when a stent is being considered or the question is not yet answered.

Risk Factors

Some patients are more likely to develop this condition. Knowing your risk helps your care team take extra precautions.

Risk Factor	Why It Increases Risk
High blood pressure	Years of high pressure damage the artery wall and speed up plaque buildup.
High cholesterol (LDL)	Cholesterol drives plaque growth inside the artery wall. Higher levels for longer mean more buildup.
Smoking and vaping	Tobacco and nicotine injure the artery lining, raise blood pressure, and make clots form more easily.
Diabetes	Diabetes speeds up artery disease and can dull warning pain - so angina may feel mild or be silent.
Family history of early heart disease	A parent or sibling with heart disease before age 55 (men) or 65 (women) raises your own risk.
Obesity and inactivity	Both raise blood pressure, cholesterol, and blood sugar - all of which damage arteries.
Older age	Risk rises with age in both men and women. Symptoms in older adults are more often vague.
Chronic kidney disease	Lower kidney function speeds up artery disease and changes the medicine plan.
Stress and poor sleep	Long-term stress and untreated sleep apnea raise blood pressure and worsen angina.

Antianginal Medicines - How They Work and What to Expect

Medicine class	How it eases angina	Common side effects
Beta-blocker (metoprolol, carvedilol)	Slows the heart so it asks for less blood; lowers blood pressure	Low energy, slow pulse, cold hands and feet
Calcium channel blocker (amlodipine, diltiazem)	Relaxes the heart arteries so more blood gets through; lowers blood pressure	Ankle swelling, headache, flushing
Long-acting nitrate (isosorbide)	Relaxes the arteries; eases the heart's workload	Headache, low blood pressure - needs a daily nitrate-free window
Ranolazine (Ranexa)	Calms the heart muscle's response to low oxygen	Nausea, dizziness, constipation; some drug interactions
Ivabradine (Corlanor)	Slows the heart without lowering blood pressure - used when beta-blockers are not tolerated	Bright spots or flashes in vision (usually mild and reversible)
Short-acting nitroglycerin (sublingual or spray)	Opens the arteries within minutes - for use when angina starts	Headache, brief low blood pressure - sit down before using

CCS Class I to IV - How Doctors Grade Angina by Effort Needed

Class I

- Heavy or prolonged effort only
- No angina with everyday activity
- Examples: shoveling snow, running

Class II

- Slight limit on usual activity
- Angina with brisk walking or stairs
- Worse with cold, wind, or after a meal

Class III

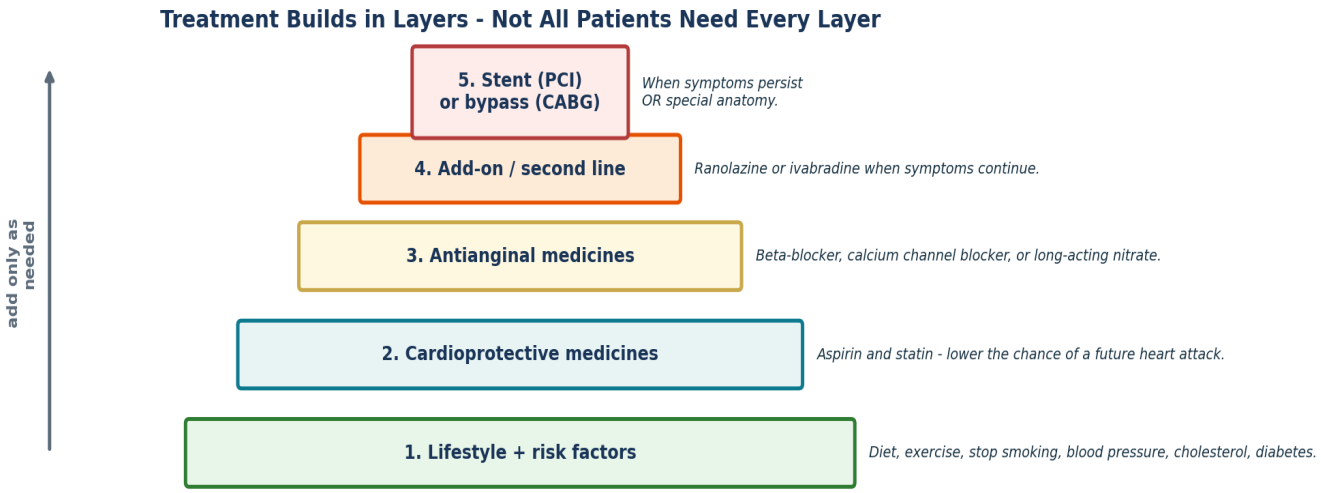
- Marked limit on activity
- Angina with one flight of stairs at normal pace
- Cannot walk one or two blocks

Class IV

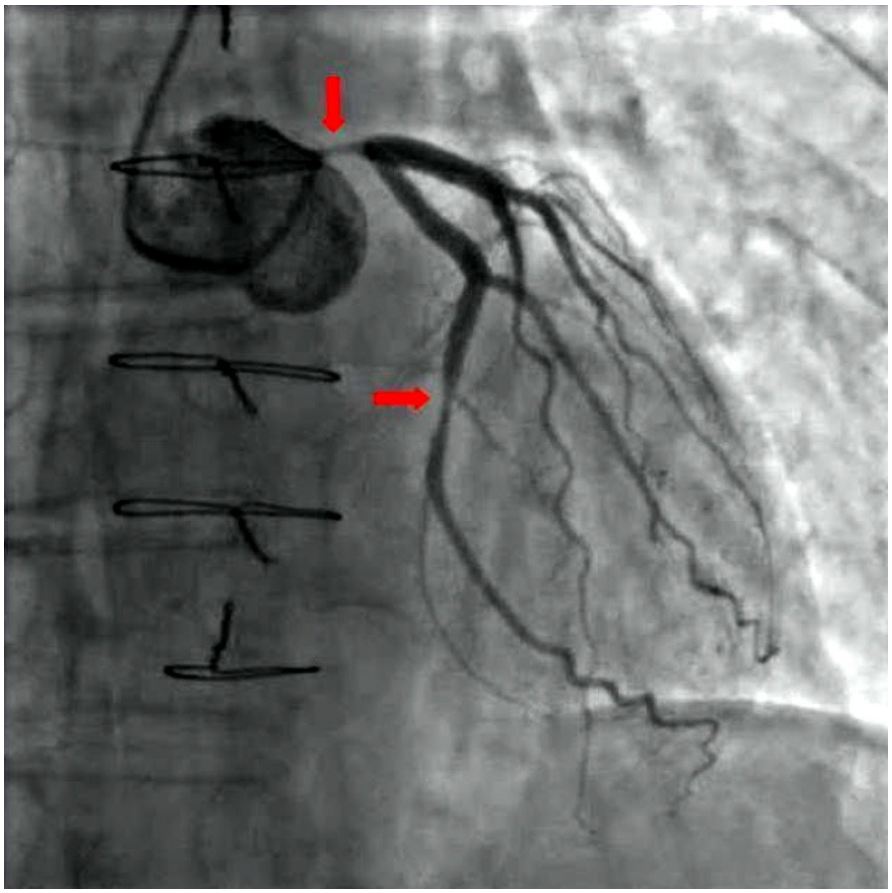
- Cannot do any effort without angina
- Angina may come at rest
- Call 911 if this is new for you

Treatment Options

- Stop smoking. This is the single most powerful step.
- Take a high-intensity statin. It lowers LDL cholesterol and calms artery inflammation - lowers the chance of a heart attack for the long run.
- Take a low-dose aspirin once your doctor agrees it is right for you.
- Pick one antianginal medicine first - usually a beta-blocker or a calcium channel blocker - to lower how often angina happens.
- Keep a fast-acting nitroglycerin tablet or spray nearby. Use it when angina starts. Sit down first; do not stand or walk while you take it.
- Move your body every day - 30 minutes of brisk walking is the target for most patients. Cardiac rehab makes this safer and more effective.
- Treat blood pressure, blood sugar, and sleep apnea. These all change the disease underneath the symptom.
- Plan for an angiogram or stent only if symptoms continue on a good medicine plan, the heart pumping is weak, or the anatomy is high-risk (left main, severe multivessel disease).



Treatment is layered: lifestyle and cardioprotective medicines are the foundation. Antianginal medicines ease symptoms. Stents or bypass come in when those layers are not enough.



A real coronary angiogram showing a high-grade narrowing - the same kind of lesion that causes stable angina. Image credit: Pantaleo et al. via Wikimedia Commons (CC BY 2.0).

When a Stent or Bypass Is Strongly Considered (Special Anatomy)

Pattern	Why it changes the plan
Left main disease	The left main supplies most of the heart - even one tight narrowing here is high-risk. Bypass or sometimes a stent is preferred.
Severe multivessel disease	Three-vessel disease, especially with diabetes or a weak heart, often does better with bypass surgery.
Weak heart muscle (low ejection fraction)	When the pumping is weak, opening the arteries can help the muscle recover. Discussed case by case.
Ongoing angina on a full medicine plan	When symptoms continue despite two or three antianginal medicines, a stent can ease the angina even if it does not add years to life.

The Daily Plan - What Most Patients Actually Take

- Aspirin (low dose), once a day, for life.
- A high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg), once a day, for life.
- One antianginal medicine to ease symptoms - usually a beta-blocker or a calcium channel blocker.
- A blood-pressure medicine (an ACE inhibitor, an ARB, or a diuretic), if blood pressure is still high.
- A diabetes medicine that protects the heart (an SGLT2 inhibitor like empagliflozin or dapagliflozin), if you have diabetes.
- Short-acting nitroglycerin - kept nearby for a flare-up. Sit down first. One tablet or spray; second dose if needed; 911 if it does not ease.

When We Choose Angiogram First vs Medicines First

- **Medicines first** is the default for most patients with stable angina - the ISCHEMIA trial showed this gives the same number of years as a stent.
- **Angiogram first** is preferred when angina is severe and limits daily life, when the stress test shows a large area of low blood flow, or when the heart pumping is weak.
- **CT angiogram first** is a middle path - a clear picture of the arteries without going to the cath lab. Often answers the question in one test.
- **Straight to the cath lab** when angina comes at rest, lasts longer, or is new for you - that is unstable angina and is part of the heart-attack family.
- We make the choice with you - we map out the trade-offs and let you decide alongside the team.

What Cardiac Rehab Adds - Often Underrated

- Cardiac rehab is a 12-week supervised program - exercise, education, blood-pressure and sugar tuning, and counseling.
- It lowers the chance of a heart attack and death by 20 to 30 percent in patients with coronary disease.
- It is one of the most powerful treatments we have - and one of the most underused. Most insurance plans cover it after a heart attack, stent, bypass, or stable angina diagnosis.
- It is safe, even for older adults and patients with a weak heart - the team monitors you during exercise.
- If formal rehab is not available, our office can guide a home plan - less effective but better than no rehab.

Stable Angina Is Part of a Bigger Picture - Where to Read Next

- Stable angina sits inside the family of coronary artery disease. We have separate guides for each piece.
- How chest pain is sorted out at the visit: see the Chest Pain guide.
- The underlying artery disease: see the Coronary Artery Disease guide.
- When stable angina becomes a heart attack: see the Heart Attack (ACS) guide.
- Artery spasm as a less common cause: see the Coronary Vasospasm guide.
- A torn artery (more often in younger women): see the SCAD guide.
- How stents are placed: see the Angioplasty and Stents guide.
- How echocardiograms look at the heart: see the Echocardiogram guide.
- How stress testing works: see the Stress Testing guide.
- How a CT angiogram works: see the Coronary CTA guide.
- How calcium score helps with risk: see the Coronary Calcium Score guide.
- Statin therapy for cholesterol: see the Statin Therapy guide.
- Lifestyle - heart-healthy eating: see the Heart-Healthy Eating guide.
- When a weak heart follows years of artery disease: see the HFrEF (Heart Failure) guide.

The ISCHEMIA framing in plain English. For most patients with stable disease, taking the medicines and following the lifestyle plan adds the same number of years as starting with a stent. That is good news - it means you can take time to make the decision. Stents are still the right answer when symptoms continue or the anatomy is high-risk.

Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
Medicines + lifestyle (first-line)	Daily medicines may cause low energy, low BP, headaches, or muscle aches.	Lowers heart attack and death risk. Eases angina. As good as a stent for survival in most stable disease.	Add a stent later if symptoms continue.
Coronary CT angiogram	Radiation and dye. May find narrowings that did not need treating.	A clear picture of the arteries without going to the cath lab.	Stress test, or cath if symptoms are severe.
Heart catheterization (angiogram)	Bleeding, dye reaction, vessel injury, rarely stroke or kidney strain.	Most detailed look at the arteries. Can open a narrowing in the same visit.	CT angiogram first when the question allows.
Stent (PCI) for ongoing angina	Bleeding, dye reaction, rarely stroke. Stent re-narrowing in a small share.	Eases angina when medicines do not. Does not by itself add years in stable disease.	More antianginal medicine first; bypass for some anatomies.
Bypass surgery (CABG)	Open-heart surgery: longer recovery, breastbone healing, stroke risk.	Best long-term result for left main, severe multivessel, diabetes, or weak heart.	Stent (PCI) for some patients.
Cardiac rehab	Takes time — about 12 weeks of supervised sessions.	Lowers heart attack and death risk. Less angina, better stamina.	Home program with our team if formal rehab is not available.

Common Misconceptions

Myth	Reality
I have heart disease, so I need a stent.	For most stable disease, medicines plus lifestyle work as well as a stent for survival (ISCHEMIA trial). Stents help when angina continues or anatomy is high-risk.
Angina is just part of getting old.	Angina is not normal aging. It is a warning that an artery is narrowed — treatable, and worth treating.
If I am not having pain now, my arteries are fine.	Plaque keeps building between flare-ups. People with stable angina can still have a heart attack. Daily medicines lower that risk.
The ISCHEMIA trial means stents do not work.	Stents do work — they ease angina, and they are needed for left main, severe multivessel, or weak-heart anatomy. ISCHEMIA showed medicines alone match stents for survival in most stable disease.
Nitroglycerin will fix the problem.	Nitroglycerin opens arteries for a few minutes and eases a flare-up. It does not change the underlying disease — daily medicines and lifestyle do.
If aspirin and a statin are not enough, I have failed.	Most patients need more than one medicine. Adding a beta-blocker, calcium channel blocker, ranolazine, or ivabradine is normal. We build the plan in steps.
Women do not get angina.	Women get angina too. Symptoms are more often shortness of breath, jaw or back discomfort, or unusual tiredness. Microvascular angina is more common in women.
Bypass surgery is the old-fashioned option.	Bypass is still the best long-term answer for left main, severe multivessel, diabetes, or a weak heart. Not 'less modern' — better for that anatomy.

Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Heart attack (acute coronary syndrome)	The same plaque that causes angina can rupture and form a clot - turning stable angina into a heart attack. See our Heart Attack (ACS) guide.
Heart failure from a weakened muscle	Years of low blood flow, or a past heart attack, can leave the heart pumping weakly. See our HFrEF guide.
Dangerous heart rhythms	Ischemia can trigger atrial fibrillation, ventricular tachycardia, or ventricular fibrillation. Treat the underlying disease and the rhythm.
Sudden cardiac arrest	Rare in stable disease, but still possible - especially with a heavy plaque burden or a previous heart attack. See our Sudden Cardiac Arrest guide.
Stent narrowing or clotting (after PCI)	A small share of stents narrow again or clot. The risk is lowest when blood-thinner pills are taken every day for the first months.
Side effects from antianginal medicines	Low blood pressure, slow heart rate, swelling, headaches, or fatigue. Most are mild and reversible with a dose change.
Anxiety and avoidance	Fear of bringing on angina can stop patients from being active - which makes the disease worse. Cardiac rehab and counseling help.

Cardioprotective Medicines - the Long-Run Plan

Medicine	What it does	Why we use it
Aspirin (low dose)	Makes blood platelets less sticky	Lowers the chance of a heart attack and clot - for most patients, taken for life
High-intensity statin	Lowers LDL cholesterol and calms artery inflammation	Lowers heart attack and stroke risk; slows or shrinks plaque
ACE inhibitor or ARB	Lowers blood pressure and protects the heart's pumping	Used when there is also high blood pressure, diabetes, or a weak heart
SGLT2 inhibitor (for diabetes / heart failure)	Lowers blood sugar; protects the heart and kidneys	Lowers heart-attack and hospital risk in patients with diabetes or heart failure
Influenza + COVID vaccines	Lower the chance of a major infection	Infections can trigger heart attacks - vaccines lower that risk

Microvascular Angina - When the Scans Look Clean

- Some patients - more often women - have angina with a stress test that is abnormal but a coronary CT or angiogram that looks clean.
- The problem is in the very small arteries that scans cannot see well. These vessels are still part of the heart's blood supply.
- It is real disease, not 'all in your head.' It deserves the same workup and care as larger-artery disease.
- The treatment plan is similar - lifestyle, statin, blood pressure control, and antianginal medicines (often a calcium channel blocker first).
- For deeper detail, see our Coronary Microvascular Dysfunction guide.

Points to Know

If you remember nothing else, remember these key points.

- Stable angina is chest pressure, tightness, or shortness of breath with effort. It goes away with rest.
- A new pattern - at rest, longer, or more often - is a red flag. Call 911.
- Most patients are treated with medicines + lifestyle. Stents help when symptoms continue or anatomy is high-risk.
- Daily aspirin and a high-intensity statin lower the chance of a heart attack for the long run.
- Keep nitroglycerin nearby. Sit down before taking it. Call 911 if pain does not ease after the second dose 5 minutes apart.
- Move your body every day. Cardiac rehab is one of the most powerful treatments and is often covered by insurance.
- Stop smoking. This is the single most powerful step you can take.
- Tell us about a change in pattern - new triggers, longer episodes, or angina at rest.

When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- Chest pressure, tightness, or pain that lasts more than a few minutes, comes at rest, or is new for you - call 911.
- Chest discomfort with shortness of breath, sweating, nausea, or pain spreading to the arm, jaw, neck, or back - call 911.
- Angina that does not ease after two doses of nitroglycerin 5 minutes apart - call 911.
- A change in your usual angina pattern - more often, lasting longer, or with less effort than before - call us the same day.
- Side effects from a new medicine - low blood pressure, dizziness, fast heartbeat, swelling, or muscle aches - call us.
- Trouble paying for the medicines or finding cardiac rehab - call our office so we can adjust the plan.
- Questions about exercise, sex, work, or travel after a stable-angina diagnosis - call us; these are normal and important.

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How to use nitroglycerin safely. Sit down first. Place one tablet under the tongue or use one spray. Wait 5 minutes. If pain continues, take a second dose and call 911. Do not take a third dose - the next call is for help. Never use it after sildenafil (Viagra) or tadalafil (Cialis) within 24-48 hours.

Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- American Heart Association - Angina (Chest Pain) - Plain-language overview of stable vs unstable angina and when to seek help.
- Cleveland Clinic - Angina - Patient-friendly overview of stable, microvascular, and variant angina, with lifestyle and treatment notes.
- Mayo Clinic - Angina - Symptom-focused overview, risk factors, and lifestyle measures.
- NHLBI - Angina - US National Heart, Lung, and Blood Institute overview of angina causes, diagnosis, and treatment.
- MedlinePlus - Angina - US National Library of Medicine overview of angina symptoms and treatment.
- AHA - Cardiac Rehabilitation - Why cardiac rehab matters and what to expect from a 12-week program.

Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA Guideline for the Management of Patients With Chronic Coronary Disease (Virani et al., Circulation 2023; PMID 37471501) *[Guideline]*
  Primary framework for stable angina (chronic coronary disease) - lifestyle and risk factor optimization, antianginal medication choices, cardioprotective therapy, and revascularization decision-making.
- 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization (Lawton et al., Circulation 2022; PMID 34882435) *[Guideline]*
  PCI vs CABG decision-making for stable disease, including left main, multivessel, and patients with reduced ejection fraction.
- Initial Invasive or Conservative Strategy for Stable Coronary Disease (ISCHEMIA trial; Maron et al., NEJM 2020; PMID 32227755) *[Clinical Study]*
  Pivotal evidence that an initial invasive strategy did not reduce cardiovascular events compared with optimal medical therapy alone in stable CCD - foundation for the 'medicines first' framing in shared decision-making.
- Percutaneous Coronary Intervention in Stable Angina (ORBITA): a double-blind, randomised controlled trial (Al-Lamee et al., Lancet 2018; PMID 29103656) *[Clinical Study]*
  Sham-controlled trial that questioned the symptomatic benefit of PCI over medical therapy in single-vessel stable angina. Used to frame the misconception that 'a stent will fix my angina symptoms' more nuanced.
- Canadian Cardiovascular Society Grading of Angina Pectoris (Campeau, Circulation 1976; PMID 1248803) *[Clinical Concept]*
  Original CCS Class I-IV grading framework still used by clinicians today for staging stable angina by symptom limitation.
- American Heart Association - Angina (Chest Pain) *[Patient Education]*
  Plain-language patient-voice overview of stable vs unstable angina, common triggers, and when to seek help. Used for framing only; clinical numbers re-verified against guideline sources.
- Cleveland Clinic - Angina *[Patient Education]*
  Patient-friendly explanation of stable angina patterns, microvascular angina, and Prinzmetal (variant) angina. Cross-checked against ACC/AHA 2023 CCD guideline.
- Mayo Clinic - Angina *[Patient Education]*
  Patient-voice symptom descriptions and lifestyle measures for stable angina; helpful for plain-English phrasing of common triggers.
- NHLBI - Angina *[Patient Education]*
  US National Heart, Lung, and Blood Institute overview of angina types, causes, diagnosis, and treatment - a federally-sourced reference for patients.
- MedlinePlus - Angina *[Patient Education]*
  US National Library of Medicine consumer-health overview of angina, with links to community resources.

- Ranolazine for Chronic Stable Angina (CARISA trial; Chaitman et al., JAMA 2004; PMID 14722146) *[Clinical Study]*
  Evidence base for ranolazine as an add-on antianginal medicine when beta-blockers, calcium channel blockers, or long-acting nitrates alone are not enough.
- Ivabradine and Outcomes in Chronic Heart Failure (SHIFT trial; Swedberg et al., Lancet 2010; PMID 20801500) *[Clinical Study]*
  Heart-rate-lowering evidence base for ivabradine, used as an antianginal alternative when beta-blockers are not tolerated.
- AHA - Cardiac Rehabilitation *[Patient Education]*
  Cardiac rehab framing for stable angina - secondary-prevention exercise, education, and risk-factor optimization.

About This Guide

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Reviewer note: Reviewed against the AHA Angina page, the Cleveland Clinic Angina page, and Mayo Clinic's angina overview. Ours adds: a demand-vs-supply pictogram, a five-step diagnostic ladder, a layered treatment-pyramid diagram, the CCS Class I-IV grade cards, an RBA table for angiogram-first vs CT-first and for PCI vs medicines, the ISCHEMIA / ORBITA framing in plain English, and a 'where to read next' map to the related guides.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.

Take This Guide With You

Scan or visit: https://go.riasalimd.com/stable-angina-guide

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