coronary artery disease accounts for over 30% of deaths in Western countries.

**Unstable angina:**
- ischaemic chest pain with is recent in origin, is more frequent, severe, or prolonged than the patient’s usual angina; is more difficult to control with drugs; or is occurring at rest or with minimal exertion
- biomarkers are not elevated

**Thrombolysis:**
- reperfusion can be obtained with fibrinolytic therapy or PCI
- a combination of fibrinolytic and PCI can also be used
- in the CURE trial, patients who received fibrinolytic therapy in addition to aspirin within 6 hours of symptom onset had a 21% reduction in mortality compared to those who received aspirin alone
- there are two classes of fibrinolysis agents: (i) tissue plasminogen activator (tPA) and (ii) streptokinase

**Management:**
- aspirin 300mg is given to all patients with STEMI unless contraindicated
- intravenous unfractionated heparin should be administered to all patients with STEMI
- glycoprotein IIb/IIIa inhibitors should be considered for patients with STEMI
- beta blockers should be considered for patients with STEMI
- ACE inhibitors should be started as soon as possible
- beta blockers should be continued for 1-2 months following STEMI

**Risk factors:**
- age
- male gender
- smoking
- hypertension
- diabetes
- hypercholesterolaemia
- family history

**Thrombolytics:**
- recombinant tissue plasminogen activator (rtPA)
- streptokinase
- urokinase
- streptokinase is no longer used
- rtPA is preferred

**Antithrombotic therapy:**
- aspirin (300mg)
- clopidogrel
- ticlopidine and clopidogrel (thienopyridins) are second generation platelet inhibitors acting independently and theoretically synergistically with aspirin

**Statins:**
- decrease risk of adverse ischaemic events in patients with CAD
- decrease risk of heart failure
- decrease risk of peripheral arterial disease
- decrease risk of stroke

**Beta blockers:**
- iv beta blockers should be considered for patients with tachycardia or hypertension post infarct in the acute setting
- oral beta blockers decrease mortality after myocardial infarction and should be administered to all patients who can tolerate them

**Angiotensin converting enzyme inhibitors (ACEIs):**
- SAVE trial showed that captopril in patients with EF<20% post AMI lead to a 21% reduction in mortality
- ISIS-4 showed a smaller reduction in mortality for all patients treated with captopril post AMI
- HOPE showed patients with vascular disease or high risk of atherosclerosis benefited from ramipril

**ACEIs:**
- reduce mortality in patients with heart failure
- decrease risk of heart failure
- decrease risk of stroke

**Statins:**
- reduce risk of adverse ischaemic events in patients with CAD
- decrease risk of heart failure
- decrease risk of peripheral arterial disease
- decrease risk of stroke