

## Will Innovations in the 2019 ESC Guidelines for Chronic Coronary Syndromes Change the Approaches of Cardiologists?

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Coronary heart diseases (CHD) and myocardial infarction are the most widespread diseases on the human population [1]. Globally, CHD is the leading cause of morbidity and mortality in the world. Despite the reduction in the number of patients dying from this disease due to improvements in medical treatment and revascularization, unfortunately the number of individuals with CHD is rapidly increasing [2]. Cardiovascular diseases can be prevented by appropriate diet, education, abandonment of harmful habits and healthy lifestyle. In addition, screening programs and risk reduction strategies can reduce the prevalence of CHD and can provide early detections for this [3]. For the reasons mentioned above, a new guideline was published in 2019 and we will talk about shortly the innovations that this guideline has brought.

In this guideline, the term stable coronary artery disease (CAD) has been omitted. This guideline has mentioned that coronary artery disease is a dynamic process, lifestyle changes and medical/ invasive treatments may stabilize this disease or it may result with acute events if the patients take inadequate therapy and they have inappropriate lifestyle. According to this guideline, the patients may present 6 different scenarios to physicians: a) the patients who present with stable angina or dyspnoe b) patient with new onset of heart failure or left ventricular dysfunction c) patient with recent revascularization (<1 year) who had stabilized or unstabilized symptoms d) symptomatic/asymptomatic patients who had initial diagnosis or revascularization before last one year. e) the patients with vasospastic or microvascular angina f) individuals with CAD detected by screening. Another novelty is to detect individuals with CAD by adding clinical likelihood of CAD to the pretest probability (PTP). The guideline also schematized a 6-step method to facilitate diagnostic approach to the patients. The most striking points in this scheme are medical treatment recommendations without revascularization for fragile patients with potential CAD, the use of PTP test with clinical likelihood CAD and the determination of appropriate invasive and noninvasive tests [4].

Which other innovations are there in this guideline? Among noninvasive tests, coronary CT-angiography and functional ischemic tests were prioritized and especially exercise

ECG lost its popularity. Exercise ECG use is has been limited in this guideline. Exercise ECG has been recommended to evaluate only exercise intolerance, symptoms during exercise, arrhythmias, blood pressure response and event risk (in selected patients). Beta blockers have lost their importance on medical treatment. It has been specified that calcium channel blockers can be used for initial treatment instead of beta blockers. Cholesterol target levels have been lowered (LDL <50 mg / dl). Ezetimibe and PCSK9 combinations have been recommended if target LDL levels are not reached with intensive statin use. Also major changes have been made in antiaggregant treatments which are the cornerstone of medical treatment. It has been emphasized that aspirin can be used as a second antithrombotic drug for a long time in patients with high risk of ischemic event and low bleeding risk. In addition, in patients with sinus rhythm after revascularization, the dual antiplatelet therapy use duration may change according to high risk of ischemia and bleeding risk according this guideline. For the first time, prasugrel and ticagrelor use in high-risk situations in elective procedures other than acute coronary syndrome has been stated. In patients with atrial fibrillation who underwent revascularization, oral anticoagulant therapy (OAC) (first choice NOAC) can be used in triple treatment and the triple treatment can be extended up to 6 months in case of high stent thrombosis risk. Alternative dual therapy with ticagrelor or prasugrel by adding OAC can be suggested instead of triple therapy. The use of proton-pump inhibitors (PPI) has been emphasized, especially in patients with high risk of gastrointestinal bleeding. The patients with long standing CAD should be followed up at regular intervals because of the dynamic process of CAD. The importance of screening asymptomatic individuals has been emphasized and the SCORE risk estimation system should be used especially in individuals over 40 years of age who are not in high risk group. Also, the imaging methods can be used in these individuals when necessary according to this guideline. Other innovations include the use of glucagon-like peptide 1 receptor antagonist (GLP-1ra) and sodium glucose cotransporter inhibitors (GGTL-2) in diabetic coronary artery disease and use of coronary sinus constriction processes in patients with refractory angina [4].

### Editorial Comments:

Although the new guideline seems to provide convenience in diagnosis and treatment, it may cause to create disagreements among cardiologists. Rather than exercise ECG which is at hand of all cardiologists, the use of other methods can make them dependent on other branches that deal imaging methods. In addition, these tests cannot be performed in all clinics and impose financial burdens on countries may complicate to implement these recommendations every countries. Most of cardiologists will still seem to continue using of exercise ECG for diagnosis because of these reasons. Also, the habit of using betablockers prescribed for years may leave the physicians in the dilemma. Prolonged use of multiple antiplatelet agents may not be supported by physicians because of their anxiety about bleeding.

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