

of ARBs (e.g., valsartan, losartan) is reasonable for patients who are intolerant of ACE-inhibitor therapy. The aldosterone receptor antagonist eplerenone (25 mg/day, titrated to 50 mg/day) is indicated as additive therapy to ACE or ARB in MI patients who have reduced EF (<40%) or diabetes. Careful monitoring of serum potassium is required after initiation of eplerenone together with ACE or ARB.

Beta blocker therapy reduces mortality risk in patients who have reduced EF post-MI. This therapy should be avoided in patients with uncompensated heart failure early after MI or the presence of other contraindications. Metoprolol succinate (25 mg/day titrated up to 200 mg/day) or carvedilol (3.125–6.25 mg titrated to 25 mg twice each day) should be initiated at low doses and titrated upward as tolerated. The role of beta blockers in patients with no residual myocardial ischemia, arrhythmias, or normal EF is not clear.

Nitrates, either short-acting sublingual nitroglycerin or long-acting versions, may be useful in the treatment of stable angina. Calcium channel blocking drugs should be avoided in patients with reduced EF (<40%). In patients with normal EF, either diltiazem or verapamil may be useful as a substitute in patients who are intolerant of β -blockers when either antianginal therapy or rate control for AF is needed. The dihydropyridine, amlodipine, may be a useful adjunct for control of hypertension or treatment of angina. It should be used with caution in the face of reduced EF.

After acute MI, women should refrain from initiating hormone therapy with estrogen or estrogen/progesterone preparations; these agents do not decrease the risk of recurrent MI but do increase the risk of thromboembolic events. The ongoing use of hormone therapy in women already receiving treatment should be individualized, with a bias toward discontinuing therapy. Diabetic patients need attention to their degree of glycemic control, with a target of hemoglobin A_{1c} less than 7%. Vitamin supplements have no clear role in therapy for MI patients. Fish oil supplements do not appear to benefit patients who have experienced acute MI.

Patient Education and Cardiac Rehabilitation

It is important to begin the education of patients early after acute MI so that they understand the value of their various prescribed

medical therapies and the need for risk factor modification. Cardiac rehabilitation programs are very useful in the ongoing education of patients; they reinforce positive lifestyle changes and provide exercise training in the post-MI period. Such programs not only educate patients but also help them to regain confidence in their ability to perform the tasks of daily living and other activities they enjoy. Early follow-up with the physician after discharge is also important to ensure clinical stability and tolerance of medical therapy and to monitor the progress of lifestyle changes.

SUGGESTED READINGS

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