

fright, or frustration) and are relieved by rest, they also may occur at rest (Chap. 294) and while the patient is recumbent (angina decubitus). The patient may be awakened at night by typical chest discomfort and dyspnea. Nocturnal angina may be due to episodic tachycardia, diminished oxygenation as the respiratory pattern changes during sleep, or expansion of the intrathoracic blood volume that occurs with recumbency; the latter causes an increase in cardiac size (end-diastolic volume), wall tension, and myocardial oxygen demand that can lead to ischemia and transient left ventricular failure.

The threshold for the development of angina pectoris may vary by time of day and emotional state. Many patients report a fixed threshold for angina, which occurs predictably at a certain level of activity, such as climbing two flights of stairs at a normal pace. In these patients, coronary stenosis and myocardial oxygen supply are fixed, and ischemia is precipitated by an increase in myocardial oxygen demand; they are said to have stable exertional angina. In other patients, the threshold for angina may vary considerably within any particular day and from day to day. In such patients, variations in myocardial oxygen supply, most likely due to changes in coronary vasomotor tone, may play an important role in defining the pattern of angina. A patient may report symptoms upon minor exertion in the morning (a short walk or shaving) yet by midday be capable of much greater effort without symptoms. Angina may also be precipitated by unfamiliar tasks, a heavy meal, exposure to cold, or a combination of these factors.

Exertional angina typically is relieved in 1–5 min by slowing or ceasing activities and even more rapidly by rest and sublingual nitroglycerin (see below). Indeed, the diagnosis of angina should be suspect if it does not respond to the combination of these measures. The severity of angina can be conveniently summarized by the Canadian Cardiac Society functional classification (Table 293-1). Its impact on the patient's functional capacity can be described by using the New York Heart Association functional classification (Table 293-1).

TABLE 293-1 CARDIOVASCULAR DISEASE CLASSIFICATION CHART

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification
I	Patients have cardiac disease but <i>without</i> the resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.	Ordinary physical activity, such as walking and climbing stairs, <i>does not cause angina</i> . Angina present with strenuous or rapid or prolonged exertion at work or recreation.
II	Patients have cardiac disease resulting in <i>slight limitation</i> of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	<i>Slight limitation</i> of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, or when under emotional stress or only during the few hours after awakening. Walking more than two blocks on the level and climbing more than one flight of stairs at a normal pace and in normal conditions.
III	Patients have cardiac disease resulting in <i>marked limitation</i> of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.	<i>Marked limitation</i> of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight of stairs in normal conditions.
IV	Patients have cardiac disease resulting in <i>inability</i> to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	<i>Inability</i> to carry on any physical activity without discomfort—anginal syndrome <i>may</i> be present at rest.

Source: Modified from L Goldman et al: Circulation 64:1227, 1981.

Sharp, fleeting chest pain or a prolonged, dull ache localized to the left submammary area is rarely due to myocardial ischemia. However, especially in women and diabetic patients, angina pectoris may be atypical in location and not strictly related to provoking factors. In addition, this symptom may exacerbate and remit over days, weeks, or months. Its occurrence can be seasonal, occurring more frequently in the winter in temperate climates. Anginal “equivalents” are symptoms of myocardial ischemia other than angina. They include dyspnea, nausea, fatigue, and faintness and are more common in the elderly and in diabetic patients.

Systematic questioning of a patient with suspected IHD is important to uncover the features of an unstable syndrome associated with increased risk, such as angina occurring with less exertion than in the past, occurring at rest, or awakening the patient from sleep. Since coronary atherosclerosis often is accompanied by similar lesions in other arteries, a patient with angina should be questioned and examined for peripheral arterial disease (intermittent claudication [Chap. 302]), stroke, or transient ischemic attacks (Chap. 446). It is also important to uncover a family history of premature IHD (<55 years in first-degree male relatives and <65 in female relatives) and the presence of diabetes mellitus, hyperlipidemia, hypertension, cigarette smoking, and other risk factors for coronary atherosclerosis (Chap. 291e).

The history of typical angina pectoris establishes the diagnosis of IHD until proven otherwise. The coexistence of advanced age, male sex, the postmenopausal state, and risk factors for atherosclerosis increase the likelihood of hemodynamically significant coronary disease. A particularly challenging problem is the evaluation and management of patients with persistent ischemic-type chest discomfort but no flow-limiting obstructions in their epicardial coronary arteries. This situation arises more often in women than in men. Potential etiologies include microvascular coronary disease (detectable on coronary reactivity testing in response to vasoactive agents such as intracoronary adenosine, acetylcholine, and nitroglycerin) and abnormal cardiac nociception. Treatment of microvascular coronary disease should focus on efforts to improve endothelial function, including nitrates, beta blockers, calcium antagonists, statins, and angiotensin-converting enzyme (ACE) inhibitors. Abnormal cardiac nociception is more difficult to manage and may be ameliorated in some cases by imipramine.

PHYSICAL EXAMINATION

The physical examination is often normal in patients with stable angina when they are asymptomatic. However, because of the increased likelihood of IHD in patients with diabetes and/or peripheral arterial disease, clinicians should search for evidence of atherosclerotic disease at other sites, such as an abdominal aortic aneurysm, carotid arterial bruits, and diminished arterial pulses in the lower extremities. The physical examination also should include a search for evidence of risk factors for atherosclerosis such as xanthelasmas and xanthomas (Chap. 291e). Evidence for peripheral arterial disease should be sought by evaluating the pulse contour at multiple locations and comparing the blood pressure between the arms and between the arms and the legs (ankle-brachial index). Examination of the fundi may reveal an increased light reflex and arteriovenous nicking as evidence of hypertension. There also may be signs of anemia, thyroid disease, and nicotine stains on the fingertips from cigarette smoking.

Palpation may reveal cardiac enlargement and abnormal contraction of the cardiac impulse (left ventricular dyskinesia). Auscultation can uncover arterial bruits, a third and/or fourth heart sound, and, if acute ischemia or previous infarction has impaired papillary muscle function, an apical systolic murmur due to mitral regurgitation. These auscultatory signs are best appreciated with the patient in the left lateral decubitus position. Aortic stenosis, aortic regurgitation (Chap. 283), pulmonary hypertension (Chap. 304), and hypertrophic cardiomyopathy (Chap. 287) must be excluded, since these disorders may cause angina in the absence of coronary atherosclerosis. Examination during an anginal attack is useful, since ischemia can cause transient left ventricular failure with the appearance of a third