Consensus Panel Statement
Preventing Heart Attack and Death in Patients with Coronary Disease.
Circulation. 1995;92:2–4.

American Heart Association®
Fighting Heart Disease and Stroke

Comprehensive Risk Reduction for Patients With Coronary and Other Vascular Disease

Risk Intervention	Recommendations
Smoking: **Goal** **complete cessation**	Strongly encourage patient and family to stop smoking. Provide counseling, nicotine replacement, and formal cessation programs as appropriate.
BP control: **Goal** **<140/90 mm Hg or <130/85 mm Hg if heart failure, renal insufficiency or diabetes.**	Initiate lifestyle modification — weight control, physical activity, alcohol moderation, and moderate sodium restriction — in all patients with blood pressure ≥130 mm Hg systolic or 85 mm Hg diastolic. Add blood pressure medication, individualized to other patient requirements and characteristics (i.e., age, race, need for drugs with specific benefits) **if** blood pressure is not less than 140 mm Hg systolic or 90 mm Hg diastolic **or** if blood pressure is not <130 mm Hg systolic or 85 mm Hg diastolic for individuals with heart failure, renal insufficiency or diabetes.
Lipid management: **Primary goal** **LDL <100 mg/dL** **Secondary goals** **HDL >35 mg/dL;** **TG <200 mg/dL**	Start AHA Step II Diet in all patients: ≤30% fat, <7% saturated fat, <200 mg/d cholesterol and promote physical activity. Assess fasting lipid profile. In post-MI patients, lipid profile may take 4 to 6 weeks to stabilize. Add drug therapy according to the following guide:
LDL <100 md/dL No drug therapy	LDL 100 to 130 mg/dL Consider adding drug therapy to diet, as follows: Suggested drug therapy TG <200 mg/dL: Statin, Resin, Niacin TG 200 to 400 mg/dL: Statin, Niacin TG >400 mg/dL: Consider combined drug therapy (niacin, fibrates, statin) If LDL goal not achieved, consider combination drug therapy.	LDL >130 mg/dL Add drug therapy to diet, as follows: Suggested drug therapy TG <200 mg/dL: Statin, Resin, Niacin TG 200 to 400 mg/dL: Statin, Niacin TG >400 mg/dL: Consider combined drug therapy (niacin, fibrates, statin) If LDL goal not achieved, consider combination drug therapy.	HDL <35 mg/dL Emphasize weight management and physical activity. Advise smoking cessation. If needed to achieve LDL goals, consider niacin, statin, fibrates.
Physical activity: **Minimum Goal** **30 minutes 3 to 4 times per week**	Assess risk, preferably with exercise test, to guide prescription. Encourage minimum of 30 to 60 minutes of activity 3 or 4 times weekly (walking, jogging, cycling, or other aerobic activity) supplemented by an increase in daily lifestyle activities (e.g., walking breaks at work, gardening, household work). Maximum benefit 5 to 6 hours a week. Advise medically supervised programs for moderate- to high-risk patients.
Weight management: **Goal** **BMI 21–25 kg/m²**	Measure patient's weight and height, BMI, and waist-to-hip ratio at each visit as part of routine evaluation. Start weight management and physical activity as appropriate. Desirable BMI range: 21–25 kg/m². Desirable waist circumference <40 inches in men and <36 inches in women.
Diabetes management: **Near normal fasting plasma glucose and near normal HbA1c (<7)**	Appropriate hypoglycemic therapy to achieve near normal fasting plasma glucose as indicated by HbA1c. Treatment of other risks (e.g., physical activity, weight management, blood pressure and for cholesterol management see recommendations above.
Antiplatelet agents/ anticoagulants:	Start aspirin 80 to 325 mg/d if not contraindicated. Manage warfarin to international normalized ratio = 2 to 3.5 post-MI patients not able to take aspirin.
ACE inhibitors post-MI:	Start early post-MI in stable high-risk patients (anterior MI, previous MI, Killip class II [S_3 gallop, rales, radiographic CHF]). Continue indefinitely for all with LV dysfunction (ejection fraction ≤40%) or symptoms of failure. Use as needed to manage blood pressure or symptoms in all other patients.
Beta-blockers:	Start in high-risk post-MI patients (arrhythmia, LV dysfunction, inducible ischemia) at 5 to 28 days. Continue 6 months minimum. Observe usual contraindications. Use as needed to manage angina, rhythm, or blood pressure in all other patients.
Estrogens:	Estrogen replacement: individualize consistent with other health risks.

ACE indicates angiotensin-converting enzyme; MI, myocardial infarction; TG, triglycerides; and LV, left ventricular.