**OPTIMUM TREATMENT OF ANGINA PECTORIS SHOULD TAKE INTO CONSIDERATION PATIENTS’ CIRCULATORY STATUS AND THE PRESENCE OF ASSOCIATED COMORBIDITIES IN THE YEAR 2016.**

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Currently many treatment options, including medicines, and revascularization procedures are available to treat patients with stable angina pectoris. All patients with angina pectoris due to underlying CAD should be treated with a low dose aspirin and a high dose, potent statin, if tolerated, to reduce the occurrence of adverse clinical outcomes (sudden ischemic death, myocardial infarction, unstable angina). In addition an initial trial of antianginal drugs for the relief of angina is indicated as there is no evidence that revascularization is superior to medical therapy. The initial choice of a drug class or combination therapy can be made by taking into consideration patient’s baseline heart rate, blood pressure, and left ventricular (LV) function and any comorbidities. Because none of the antianginal drugs have been shown to improve survival, and if there are no issues with heart rate or blood pressure, or LV function, one can use either a beta- blocker (BB) or a long acting nitrate or a calcium channel blocker (CCB) or ranolazine as the first step, in addition to sublingual nitroglycerin as initial therapy. If the clinical response is inadequate, one can either substitute or add another class of drug to better control symptoms. When the LV systolic function is impaired an initial choice would be a BB, and nitrates rather than a CCB. Patients with low blood pressure and or low heart rates are good candidates for ranolazine or trimetazadine as these agents do not have any significant effects on heart rate or blood pressure or LV function. Hypertensive patients with angina need a better control of blood pressure and use of a beta-blocker or a CCB or the combination of two. Patients with significant COPD or asthma, should be treated with a CCB or a nitrate or ranolazine or ivabradine or trimetazidine and not a BB. Triple therapy may not always be more effective than dual antianginal treatment. Patients who do not respond to medical treatment need to be considered for coronary artery revascularization.