**INDIVIDUALIZATION OF OPTIMAL TREATMENT FOR STABLE ANGINA PECTORIS: AN ONGOING CHALLENGE**

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Patients with angina pectoris may have underlying obstructive or non- obstructive disease, or even normal coronary arteries, which may account for their symptoms. Many of the patients with stable angina also have co-morbidities which can influence the initial treatment choice. Unfortunately there is little trial data to substantiate Guideline recommended medical treatment when patients with stable angina have non-obstructive CAD, or normal coronary arteries. Also when common co-morbid conditions such as chronic pulmonary disease; chronic kidney disease; hypertension; low blood pressure; bradycardia; anemia; supraventricular arrhythmias or diabetes are present treatment options are opinion based rather than evidence based. Given the availability of many anti anginal drugs (beta-blockers, short and long acting nitrates; calcium channel blockers, ranolazine, ivabradine, trimetazadine, nicorandil) with different pharmacologic and hemodynamic effects, individualization of optimal treatment therefore, seems reasonable with either monotherapy or combination therapy. In addition one needs to treat co-morbidities and dyslipidemia if present. All patients with angina must abstain from smoking tobacco, and be as active as possible. Patients who do not respond to optimal medical treatment need to be evaluated for coronary artery revascularization for symptom relief. Large randomized, placebo-controlled trials are needed to fine tune treatment of stable angina, in patients who have non-obstructive CAD, or normal coronary arteries, and those with significant co-morbidities.