Personal Therapeutics

Angina

DAVID SHORT

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In order to assess the condition four questions must be answered: (1) is the patient really suffering from angina; (2) if so, is it due to coronary disease; (3) are there any aggravating factors; and (4) are there any dangerous features?

Is the patient really suffering from angina?

Attacks of pain or oppression occurring anywhere in the torso—especially in the region of the upper or middle sternum—precipitated by effort or emotion and persisting for a few minutes are virtually diagnostic of angina. Attacks that do not have this precise relationship to effort or emotion are probably due to some less serious cause.

Is the angina due to coronary disease?

A diagnosis of angina implies myocardial ischaemia, but in about 7-10% of cases it is due to non-coronary cardiovascular disease. Non-coronary causes of angina include aortic valve disease, hypertension, cardiomyopathy, mitral stenosis, and pulmonary hypertension. Occasionally no evidence of heart disease (or any other disease) can be found.

Are there any aggravating factors?

Extra-cardiac factors that aggravate angina include anaemia, thyrotoxicosis, obesity, smoking, chronic cholecystitis, duodenal ulceration, cervical spondylosis, and anxiety.

Are there any dangerous features?

Coronary arterial disease is notoriously unpredictable. Nevertheless, certain patterns of angina have a particularly serious prognosis—for example, crescendo course, recent onset (especially if abrupt), attacks of unprovoked rest pain, and failure to respond to medical treatment. (In 15-30% of patients angina subsides completely and may not return.)

General management

Remediable factors should be dealt with, and advice given on how to avoid future attacks. For cases with dangerous features (unstable angina) urgent specialist help should be sought.

Drug treatment

GLYCERYL TRINITRATE

Glyceryl trinitrate is usually sufficient in mild cases. Tablets should be sucked or chewed to relieve an attack and also before doing anything known by experience to be likely to provoke angina.

Side effects—headache and syncope.

BETA-ADRENERGIC BLOCKING DRUGS

Beta-adrenergic blocking drugs greatly help most patients with angina—but not all. Start with a low dosage—for example, propranolol (Inderal) 10 mg twice or thrice daily; double dose every three or four days until relief is obtained or the heart rate falls below 60 beats/min.

Special problems

Cardiac enlargement or an abnormal electrocardiogram—Combine beta-blockade with a diuretic or digoxin or both.

Nocturnal attacks—Slow oxprenolol (Trasicor) may be most effective.

Bronchospasm—Beta-blocking drugs should be avoided or used with great care. Metoprolol (Betaloc, Lopresor) is probably the safest.

Diabetes—Beta-blocking drugs may produce troublesome hypoglycaemic side effects in diabetic patients. Atenolol (Tenormin) and acebutolol (Sectral) are probably the best choice.

OTHER DRUGS

Sorbitrate (Gedocard, Sorbitrate)

Sorbitrate nitrate has a more gradual and in particular a more prolonged effect than glyceryl trinitrate, its action persisting from three to six hours.

Dose—2.5 to 20 mg six-hourly. The tablets are more effective when chewed than when swallowed.

Side effect—headache, which can usually be avoided by reducing the dose; later a higher dose may be tolerated.

Perhexiline maleate (Pexid)

Perhexiline maleate is often strikingly successful in relieving angina that has proved resistant to all other medical treatment.

Dose—100-200 mg twice daily.
**Side effect**—occasionally causes peripheral neuropathy and hepatic damage.

**Nifedipine (Adalat)**

Nifedipine is worth trying in patients with attacks of angina at rest—particularly those of the Prinzmetal type—who have proved resistant to other treatment.

**Dose**—10 to 20 mg eight-hourly. If a quick effect is needed, the capsule should be crushed.

Since angina often subsides spontaneously, particularly in the summer, it may not be necessary to continue drug treatment indefinitely. If the patient is getting no angina at all, the dose should be gradually reduced, and if the symptom does not return the drug should be stopped and kept in reserve.

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**MATERIA NON MEDICA**

**Amid the alien corn**

Being a lifelong insomniac I thought I had found the perfect vacation job when I applied for work on the night-shift of a well-known cereal manufacturer. The job lasted 12 weeks and was to be my last foray into the outside world before my clinical training in medicine. Only one man worked on this shift, which stretched from 10:00 pm to 6:00 am, and on our arrival we took over the machines from the women with much flatterian banter on both sides. My first impression, as I fought back the surprisingly deadening fatigue, was the deafening, relentless noise of the machinery and conveyor belts. The place teemed with men and mechanical monsters like a scene from Dante’s Inferno. My “Virgil” was a junior manager who took me around the enormous building. Boats brought corn along the ship canal to the factory, where it was piped to the upper floors to be processed, checked, and mixed with various vitamin additives. Moving downwards the products were formed into familiar breakfast cereals, and after further checks, they were packeted, weighed on conveyor belts, and loaded into lorries for distribution.

I was in “quality” and therefore made regular checks on various samples; I sat for hours with a large silver spoon in my hand poised over a moving belt of cornflakes. I removed the burnt ones. Sometimes I weighed cartons, sealed packets, or fed damaged packets into a “destructor machine.” Occasionally gigantic vats of heated cereal were pushed past my nose so that the smell of cooking cereal lingered on in my nostrils for hours. “Tea-breaks” at midnight, “lunch at 2-30 am soon became routine.

During my sojourn at the factory I rarely saw the sun and became tall, thin, and etiolated, not unlike a stick of celery. Some of my fellow workers had toiled there for years; one confided that he had 11 children. As his wife worked on the day-shift I marvellled at their obvious opportunism.

Driving to work at night, a time normally associated with rest and quietness, I was amidst a sea of men, all heading in the direction of the docks and factories. Even stranger was leaving in the morning, exhausted after the night’s work, because then I passed crowds of people yawning at bus stops, their day yet to begin, as I was going home to glorious bed. —R E GOODMAN (general practitioner, Northenden, Manchester).

**The rape of the Ar**

As I sat in the train listening to the babble of women and trying to read my grammar I became aware of a mechanised voice announcing that the seven fawry-faw would leave from platfawn faw. I wept a little because of the decadence. Even the Frenchies, who never could pronounce a thee and discarded the effeminate aitch long ago, cling steadfastly to their virile ars, doubling and even trebling them before they let them go. But first, in parenthesis, and to mitigate the disappointment of feathered friends who have come so far with me, I ought to explain that rape is not always what it seems to be. The sort I am expositulating about is as in Rape of the Lock, by Mr Pope. An American friend of mine, who is a poet, quite confidently tells me that the Pilgrim Fathers took plenty with them in the Mayflower,