

Figure 2. Management of common comorbidities associated with CCS

Regular assessment of CV risk underpins the management strategies for the conditions listed below. CV risk assessment, complemented by consideration of the individual patient's clinical needs, informs the appropriate treatment approach and the selection of pharmacological treatment.

Patients with type 2 diabetes mellitus (T2DM)

Pharmacological treatment to improve glycaemic control and reduce risk of cardiorenal complications:

Consider adding a SGLT2 inhibitor or GLP-1 RA with proven CV benefits, regardless of baseline or target HbA_{1c} level, to reduce the risk of adverse cardiorenal outcomes.

Treatment target:

HbA_{1c} ≤7%; less stringent HbA_{1c} target (e.g. ≤8%) may be appropriate in some patients (e.g. frail, older patients; patients with short life expectancy).

For further details:

Refer to the ACG [Type 2 diabetes mellitus — personalising management with non-insulin medications](#)

Patients with hypertension

Pharmacological treatment to achieve blood pressure control:

Use an ACE inhibitor, ARB or calcium channel blocker as first-line antihypertensive medications; consider thiazide/thiazide-like diuretics as alternative first line if indicated.

Treatment target:

BP <130/80 mmHg, with target adjusted based on individual patient circumstances. For example, less stringent targets (e.g. 140/90 mmHg) can be considered in older patients (≥85 years of age) or patients with pre-treatment symptomatic orthostatic hypotension.

For further details:

Refer to the ACG [Hypertension — tailoring the management plan to optimise blood pressure control](#)

Patients with chronic heart failure (CHF)

Management of patients with CCS and CHF requires a tailored approach based on several factors, including the left ventricular ejection fraction, heart failure stage, comorbidities, and patient preferences. It is generally recommended that patients with CCS and CHF be enrolled in multidisciplinary heart failure management programmes or receive multidisciplinary care, aiming to slow down the progression of heart failure, reduce hospitalisation risk and improve survival rates.

Pharmacological treatment:

Pharmacological treatment for patients with CHF is influenced by several factors, including the type of heart failure, the need for symptomatic management (such as using diuretics for fluid overload), and interventions aimed at improving prognosis. Patient-specific considerations, such as comorbidities, medication tolerability, and adherence, also play a crucial role in determining the most appropriate management strategy. For patients with reduced left ventricular ejection fraction (≤40%), an effective combination of medications typically includes SGLT2 inhibitors, angiotensin receptor-neprilysin inhibitors, mineralocorticoid receptor antagonists, and beta blockers. These medications have been shown to be effective in reducing heart failure hospitalisations and all-cause mortality, making them key components of the treatment regimen for this patient group.²² For maximum benefits, optimise and up-titrate the dosage every 1–2 weeks depending on the patient's symptoms, vital signs, and laboratory findings.

Patients with dyslipidaemia

Pharmacological treatment to optimise lipid management:

Treat with maximally tolerated dose of statin, with or without ezetimibe. The addition of PCSK9i may be needed in some patients with high baseline LDL-C or requiring stringent LDL-C targets.

Treatment target:

LDL-C <1.8 mmol/L is reasonable for most patients with CCS. A target of <1.4 mmol is recommended for patients with a history of ACS, recurrent events or considered to be at higher CV risk (e.g. with additional CV risk factors).[†]

For further details:

Refer to the ACG [Lipid management: focus on cardiovascular risk](#)

Patients with chronic kidney disease (CKD)

Pharmacological treatment to delay disease progression and reduce CV complications:

Use an ACE inhibitor or ARB titrated to maximum tolerated dose as needed, with addition of an SGLT2 inhibitor for patients with CKD and persistent albuminuria, regardless of diabetes status.

For further details:

Refer to the ACG [Chronic kidney disease — delaying progression and reducing cardiovascular complications](#)

ARB, angiotensin receptor blocker; BP, blood pressure; GLP-1 RA, glucagon-like peptide-1 receptor agonist; HbA_{1c}, glycated haemoglobin; LDL-C, low-density lipoprotein cholesterol; PCSK9i, Proprotein convertase subtilisin kexin9 inhibitors; SGLT2, sodium-glucose co-transporter 2

[†] These targets may not be feasible when LDL-C baseline levels are very high, even with the use of PCSK9i. For these patients, treatment should aim for a ≥50% reduction as starting goal.