Practice Guidelines and Principles: Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines and principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Purpose: Compelling evidence exists that risk factor intervention in persons with coronary artery disease is associated with improved quality of life, decreased need for interventional procedures, and reduced incidence of recurrent myocardial infarctions.

Key Points:
- Aggressive risk factor management improves survival and reduces recurrent events.
- Very high risk patients include those with CHD who also have acute coronary syndromes, diabetes, metabolic syndrome, smoking, those exposed to second hand smoke and other poorly controlled risk factors.
- Diabetes is an established CAD risk equivalent; patients with diabetes should have aggressive lipid and blood pressure management.
- Complete avoidance of all environmental smoke is essential.
- Initiate and continue beta-blockers and ACE inhibitors indefinitely unless contraindicated.

Gender and Racial Disparities in Coronary Artery Disease Care:
- Cardiovascular disease is the number “1” killer of both men and women in the United States in all ethnic groups.
- African Americans are more likely to die from heart disease than white Americans; these racial disparities are more pronounced among women than men. Age adjusted mortality due to heart disease is 19% greater for African-American males compared to white males; whereas, African-American females are 33% more likely to die from heart disease than white females.
- The prevalence of several risk factors for coronary artery disease such as hypertension and diabetes are higher in certain ethnic groups.
- Although there are many factors including but not limited to access to care which contribute to racial disparities, there is evidence that African American women receive less aggressive risk factor control including aspirin and statin therapy, and less optimal BP control.

References: These guidelines are based on guidelines and recommendations from: the American Heart Association/American College Cardiology; The National Heart, Lung and Blood Institute Adult Treatment Panel III Report 2004; The U.S. Public Health Service; Circulation; The Journal of the American Medical Association; The Journal of the American College of Cardiology; Lancet and the New England Journal of Medicine.

Distributed to: All primary care physicians, cardiologists, endocrinologists, cardiothoracic surgeons.

Coronary Artery Disease: Secondary Prevention

PRACTICE GUIDELINE

GUIDELINES GRADING SYSTEM

STRENGTH OF RECOMMENDATIONS: The Rochester Community-wide Clinical Guidelines Steering Committee (SC) grades recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A—SC strongly recommends that clinicians provide [the service] to eligible patients. *There is good evidence that [the service] improves important health outcomes to conclude that benefits substantially outweigh harms.*

B—SC recommends that clinicians provide [this service] to eligible patients. *There is at least fair evidence that [the service] improves important health outcomes to conclude that benefits outweigh harms.*

C—SC makes no recommendation for or against routine provision of [the service]. *There is at least fair evidence that [the service] can improve health outcomes to conclude that the balance of benefits and harms is too close to justify a general recommendation.*

D—SC recommends against routinely providing [the service] to asymptomatic patients. *There is at least fair evidence that [the service] is ineffective or that harms outweigh benefits.*

I—SC concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. *Evidence that the [service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.*

QUALITY OF EVIDENCE: The quality of the overall evidence for a service is on a 3-point scale (good, fair, poor).

Good—Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair—Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor—Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Adapted from the USPSTF grading system.
Approved 05.16.05

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<table>
<thead>
<tr>
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<th>Guideline Goal(s)</th>
<th>Coronary Artery Disease: Secondary Prevention Practice Guideline Recommendation/Intervention</th>
</tr>
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</table>
| Smoking               | Complete cessation and Complete avoidance of environmental smoke | • Assess tobacco use at every visit  
• Advise all patients to quit smoking.  
• Provide counseling, pharmacotherapy, including nicotine replacement therapy and bupropion or veranicline, and formal cessation programs as appropriate.  
• Assess exposure to environmental smoke; stress complete avoidance. |
| Lipid Management      | **Primary Goal**  | LDL < 100 mg/dL  
• Start dietary therapy in all patients (< 7% saturated fat and < 200 mg/d cholesterol).  
• Promote safe levels of physical activity and weight management.  
• Encourage increased consumption of omega-3 fatty acids in fish or 1 g/day from supplements.  
• Assess fasting lipid profile in all patients within 24 hours of hospitalization of an acute event; initiate lipid lowering medication prior to discharge.  
• The choice of lipid lowering therapy can be a function of comorbidities; however, in general, statins are considered 1st line therapy  
Add drug therapy according to the following guide:  
| LDL <100 mg/dL  
(baseline or on treatment)  
| Further LDL-lowering therapy based on clinical judgment; statins may be appropriate in the setting of LDL < 100.  
| The role of inflammatory markers in determining lipid endpoints is evolving.  
| LDL ≥ 100 mg/dL  
(baseline or on treatment)  
| Initiate or intensify LDL-lowering therapy (statins, diet or resin).  
| Consider fibrate or niacin (if low HDL or high TG).  
| Consider combined drug therapy (statin + fibrate or niacin) – if low HDL or high TG.  |
| **Secondary Goal**    | If Triglycerides ≥ 200 mg/dL, then non-HDL cholesterol should be < 130 mg/dL | Adult Treatment Panel III (ATP III) identifies the sum of LDL + VLDL cholesterol (termed non-HDL cholesterol which is the total cholesterol minus HDL cholesterol) as a secondary target of therapy in persons with high triglycerides ≥ 200 mg/dL.  
Triglycerides  
• If TG 150-199 mg/dL, emphasize weight management and physical activity.  
• If TG 200-499 mg/dL, consider fibrate or niacin after LDL-lowering therapy.  
• If TG ≥ 500 mg/dL, treat to non-HDL –C goal.  
• Consider omega-3 fatty acids as adjunct for high TG.  |
| Diabetes Management   | HbA1c ≤ 6.5 %     | • All patients hospitalized with a principal diagnosis of CAD or seen in ED or the office with new onset angina should be evaluated for diabetes.  
• An FBS result > 110 mg/dL indicates metabolic syndrome; an FBS result > 126 mg/dL on two separate occasions indicates a diagnosis of diabetes.  
• 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 cholesterol management).  |
| Weight Management     | **Weight Goal:**  | BMI <25  
Waist circumference:  
Men < 40 inches  
Women < 35 inches  
| • Calculate BMI and measure waist circumference as part of evaluation.  
| • Monitor response of BMI and waist circumference to therapy.  
| • Start weight management & physical activity as appropriate. Desirable BMI range is 18.5-24.9 kg/m2.  
| • When BMI ≥25 kg/m2, goal for waist circumference is ≤40 inches in men and ≤35 inches in women.  
| • Particularly emphasize need for weight loss and physical activity in patients with HTN, ↑ triglycerides, or ↑ glucose levels (metabolic syndrome).  
| • Small amounts of weight loss are associated with significant health benefits.  |

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</thead>
</table>
| **Blood Pressure Control** | Goal:  
<140/90 mm Hg or  
<130/80 mm Hg if diabetes or chronic kidney disease | - Initiate lifestyle modifications (weight control, physical activity, alcohol moderation, moderate sodium restriction and emphasis on fruits, vegetables and low-fat products) in all patients with BP ≥ 130 mm Hg systolic or 80 mm Hg diastolic.  
- If BP is not <140 mm Hg systolic or 90 mm Hg diastolic or if blood pressure is not <130 mm Hg systolic or 80 mm Hg diastolic for individuals with diabetes or chronic kidney disease, add blood pressure medication. Initially treat with beta-blockers or ACE inhibitors unless contraindicated.  
- BP > 130/>85 mm Hg maybe at risk for metabolic syndrome  
- Individualize treatment to other patient requirements & characteristics (i.e., age, race, need for drugs with specific benefits). |
| **Physical Activity** | Minimum Goal:  
30 minutes (5) times per week.  
Optimal daily. | - Assess risk, preferably with exercise test, to guide prescription.  
- Avoidance of a sedentary lifestyle is important. There is incremental benefit to exercise and even lower levels of exercise may be beneficial.  
- Encourage a minimum of 30 to 60 minutes of moderate intensity aerobic activity, preferably daily, or at least (5) times weekly (brisk walking, cycling,) supplemented by an increase in daily lifestyle activities (e.g. walking breaks at work, using the stairs, gardening, household work).  
- Advise medically supervised programs for moderate to high risk patients. |
| **Beta Blockers** | Start and continue indefinitely unless contraindicated | - Start in all post-MI and acute ischemic syndrome patients.  
- Continue indefinitely.  
- Observe usual contraindications.  
- Use as needed to manage angina, rhythm or BP in all other patients. |
| **Renin-Angiotensin - blockers** | Start and continue indefinitely unless contraindicated | - ACE inhibitors can be started and used indefinitely in all patients with left ventricular EF < 40%, HTN, diabetes, or chronic kidney disease, unless contraindicated.  
- ACE inhibitors in all patients indefinitely unless contraindicated.  
- Use ARBs in patients that are intolerant to ACE inhibitors and have heart failure, or have had an MI with a left EF < 40%  
- Consider ARB’s in patients who are intolerant to ACE inhibitors. |
| **Antiplatelet Agents/ Anticoagulants** | Start and continue indefinitely unless contraindicated | - Start and continue indefinitely 81 mg to 162 mg/day unless contraindicated.  
- The evidence is insufficient to support routine testing for aspirin resistance.  
- Consider clopidogrel 75 mg/day or warfarin if aspirin contraindicated.  
- Initiate clopidogrel in combination with aspirin in acute coronary syndromes and in the post percutaneous stenting setting; duration of clopidogrel therapy is a function of whether the stent is bare metal or drug eluting.  
- Manage warfarin to INR = 2 to 3 in post-MI patients when clinically indicated or for those not able to take aspirin or clopidogrel. |
| **Influenza Vaccination** |  | - Influenza vaccine is recommended for patients with cardiovascular disease. |

* Depression -- The prevalence of major depression in the setting of CAD is approximately 20% and minor depression is 27%. After acute MI, depression is a risk factor for mortality independent of cardiac disease severity. Antidepressants have been shown in clinical trials to be effective in treating depression in acute coronary syndromes. However, AT THIS TIME, clinical trials have not demonstrated that treating depression with medication and/or counseling improves survival.  
** Vitamin E -- The evidence does not support the use of Vitamin E in the secondary prevention of Ischemic Heart Disease; note – HIGH DOSAGE Vitamin E (> 400 IU/day) may increase all-cause mortality and should be avoided.  
*** Estrogen – The evidence does not support the use of Estrogen in the secondary prevention of Ischemic Heart Disease.

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# Patient Tracking Tool for Secondary CVD

**Name:** _______________________________________________________________________________________

**Date of Birth:** ______________________  **Age:** _____________  **Sex:** ______________

<table>
<thead>
<tr>
<th>RISK INTERVENTIONS</th>
<th>INITIAL STATUS</th>
<th>PATIENT GOAL</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking</strong></td>
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<tr>
<td>Complete avoidance/cessation</td>
<td>Smoker Non-smoker</td>
<td>Smoker Non-smoker</td>
<td>Smoker Non-smoker</td>
<td>Smoker Non-smoker</td>
<td>Smoker Non-smoker</td>
<td>Smoker Non-smoker</td>
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<td><strong>Blood Pressure</strong></td>
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<tr>
<td>≤ 140/90 mm Hg or ≤ 130/80 mm Hg if diabetes or chronic kidney disease</td>
<td>mmHg</td>
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<td><strong>Cholesterol</strong></td>
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<tr>
<td>LDL &lt; 100</td>
<td>Total:</td>
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<tr>
<td>HDL &gt; 40</td>
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<tr>
<td>TG &lt; 150</td>
<td>HDL:</td>
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<tr>
<td>If TG ≥ 200 mg/dL, then non-HDL should be &lt; 130 mg/dL</td>
<td>TG:</td>
<td></td>
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<tr>
<td><strong>Physical Activity</strong></td>
<td>Duration:</td>
<td>Frequency:</td>
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<tr>
<td>Optimal=30 minutes daily or at least 5 times per wk</td>
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<tr>
<td><strong>Weight Mgmt.</strong></td>
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<tr>
<td>BMI: ≤ 25</td>
<td>Height:</td>
<td></td>
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<td></td>
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<tr>
<td>Height:</td>
<td>Weight:</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Waist Circumference:</td>
<td>BMI:</td>
<td></td>
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</tr>
<tr>
<td>Men ≤ 40 inches</td>
<td>Waist Circ:</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Women ≤ 35 Inches</td>
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<tr>
<td><strong>Diabetes Mgmt.</strong></td>
<td>HbA1c:</td>
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<tr>
<td>HbA1c ≤ 6.5%</td>
<td>HbA1c:</td>
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<tr>
<td>FBG;</td>
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<tr>
<td><strong>Antiplatelet Agents/Anticoagulants</strong></td>
<td>Yes/No</td>
<td>Compliant?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>Yes/No</td>
<td>Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
</tr>
<tr>
<td><strong>Ace Inhibitors</strong></td>
<td>Yes/No</td>
<td>Compliant?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>Yes/No</td>
<td>Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
</tr>
<tr>
<td><strong>Beta-blockers</strong></td>
<td>Yes/No</td>
<td>Compliant?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>Yes/No</td>
<td>Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
<td>Y/N Rx</td>
</tr>
<tr>
<td><strong>Depression Screening</strong></td>
<td>Yes/No</td>
<td></td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

(* )METABOLIC SYNDROME INCLUDES ANY 3 OF THE 5 DIAGNOSTIC MEASURES: Waist Circumference (men < 40 inches, women < 35 inches); BP ≥ 130/≥85 mm Hg; FBG: > 110; Triglycerides >150 mg/dL; HDL cholesterol (men: < 40 mg/dL, women: < 50 mg/dL)
Q: What is Coronary Artery Disease?

Coronary artery disease or CAD is a long-term process in which cholesterol and other substances slowly build up on the inner lining of the arteries that supply blood to the heart muscle. This substance is called “plaque.” Plaque buildup inside the arteries causes them to narrow, thereby, reducing the flow of blood and oxygen supply to the heart muscle.

Q: What causes Coronary Artery Disease?

There are many risk factors which contribute to the development of coronary artery disease. Your age, sex, and family history are risk factors that you cannot control. However, there are several risk factors you can control including 1) total cholesterol / LDL cholesterol levels, 2) blood pressure, 3) weight, 4) smoking, 6) activity level, and if you have diabetes, 7) blood glucose.

Q: How is Coronary Artery Disease diagnosed?

There is no single test to diagnose CAD. Your health care practitioner will ask about your medical and family history, your risk factors, and perform a physical exam. Your health care practitioner may also order one or more of the following tests: fasting lipid profile (blood test), EKG, exercise stress test, stress echocardiogram, nuclear heart scan or coronary angiography. These tests are used to not only diagnose CAD, but also to determine the extent and severity of the disease.

A Guide to Controlling Your Risk Factors

Controlling coronary artery disease begins with knowing your risk factors and taking action. It is important to note that the medical evidence is compelling that aggressive control of risk factors improves survival and decreases the likelihood of a second heart attack.

Stop Smoking and Avoid all Second-hand smoke

If you smoke, develop a plan to QUIT. Discuss the role of support groups and/or medications with your with your health care practitioner.

Cigarette smoke should be completely avoided by individuals with coronary artery disease. Recent research indicates that exposure to second hand smoke is a risk factor for experiencing a second heart related event (i.e. heart attack)

High Cholesterol

Cholesterol is soft, fat-like substance found in your blood stream. The two most important kinds of cholesterol that you need to be aware of are: low-density lipoprotein (LDL) and high density lipoprotein (HDL).

LDL is the “bad” cholesterol. When you have too much of it, it can build up on the walls of the arteries that supply the heart with blood. This causes narrowing and reduced blood flow. HDL is the “good” cholesterol because a high level of it seems to lower your risk for heart attack. See the chart below for recommended targets.
Information for Patients with Coronary Artery Disease

**PRACTICE GUIDELINE**

### Cholesterol

<table>
<thead>
<tr>
<th>Cholesterol</th>
<th>Recommended Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL - “Bad” Cholesterol</td>
<td>Less than 100 mg/dL</td>
</tr>
<tr>
<td>HDL - “Good” or Healthy Cholesterol</td>
<td>Greater than 40 mg/dL</td>
</tr>
</tbody>
</table>

*Have your cholesterol levels checked at least annually and know your results and what they mean.* More frequent testing may be indicated depending on your course of treatment. Eating plenty of fresh fruits and vegetables, exercising and avoiding smoking are simple steps you can take to help improve your cholesterol numbers. ‘Statins’ or other cholesterol lowering medications may be ordered to assist you in achieving your cholesterol goals. Discuss treatment goals with your health care practitioner.

### Diabetes

If you have diabetes, it is very important to keep your HbA1c level less then 6.5%. Diabetes accelerates the build up of plaque in artery walls that leads to coronary artery disease and puts you at higher risk of experiencing a heart attack or stroke. Lifestyle modification and medication can help you obtain an optimal HbA1c level.

### High Blood Pressure

All patients with coronary artery disease should regularly monitor their blood pressure. You should aim for a blood pressure below 140/90 mm/Hg. Individuals with diabetes should aim for a blood pressure below 130/80 mm/Hg. Changes to diet and regular exercise (monitored by your health care practitioner) can help control these numbers. In addition, your physician may prescribe medication to help you achieve goal blood pressure. It often takes more than one medication to reach goal.

### Physical Inactivity

Patients with established coronary artery disease should exercise regularly under the guidance of their health care practitioner. The frequency and intensity of your exercise program should be determined and monitored by your health care practitioner. If you have led an inactive lifestyle, your health care practitioner may complete an exercise tolerance test to determine your capabilities and identify any potential problems. You should work to the optimal goal of 30 minutes of exercise on a daily basis. You may be referred to a cardiac rehabilitation program. Physical activity will help lower your cholesterol levels, manage your stress, and improve the quality of your sleep.

### Weight Management

It is important to maintain a healthy weight to help reduce your risk for future cardiac events. Be sure your practitioner measures your weight at each visit. Your body mass index (BMI) can then be calculated using your height and weight. A healthy BMI is considered 25 or less. If you are overweight, develop a plan for weight loss with your health care practitioner that includes the right balance of physical activity and caloric intake to meet your goals.
Information for Patients with Coronary Artery Disease

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Depression

Several studies have shown that people who have been diagnosed with coronary artery disease are at an increased risk for depression. It is important to remember that depression is a disease of the whole body and not a sign of personal weakness. The good news is that there are very effective treatments for depression, and most people who receive proper treatment find relief. Often people benefit from a combination of therapy and medication. If you have had the following feelings for two weeks or longer contact your health care practitioner

1. Do you feel sad, blue, or depressed almost all day, every day?
2. Do you get less pleasure from things such as work and friends? Have you lost interest in things you used to enjoy?

Q: Where can I find additional information and resources on coronary artery disease and its treatment?

American Heart Association
7272 Greenville Avenue
Dallas, TX 75231-4596
1-800-AHA-USA1
www.americanheart.org

Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
1-800-311-3435
www.cdc.gov

National Heart Lung and Blood Institute
Health Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
301-592-8573
www.nhlbi.nih.gov