A 72-year-old lady complains of chest pain when climbing stairs or walking uphill. The pain recedes as soon as she stops the physical activity. Four months before she was admitted to the hospital with the diagnosis of acute inferior myocardial infarction (Figure 1). The right coronary artery (RCA) was occluded and a primary percutaneous coronary intervention (PCI) with stenting on the proximal RCA was effective. Non-significant lesions (<70% stenosis) were found in the circumflex (CX) and left anterior descending coronary arteries. The evolution was uneventful. An echocardiogram revealed inferior akinesia with left ventricular ejection fraction (LVEF) 50%, and the patient was discharged home with aspirin (ASA), Prasugrel, Enalapril 5 mg/b.i.d., Carvedilol 12.5 mg/b.i.d., and Atorvastatin 40 mg.

Blood pressure is 115/75 mmHg, heart rate 60 b.p.m., cholesterol LDL 130 mg/dL, and glucose 110 mg/dL. She is 160 cm tall and her weight is 75 kg. Figure 2 shows her electrocardiogram (ECG).

The complaints did not improve adding a long-acting nitrate, and the decision was to review the coronary anatomy. During a staged procedure (2nd revascularization), a stent was implanted in both the LAD and CX arteries that presented the same non-significant/borderline lesion. Fractional flow reserve (FFR) was not measured. Enalapril was discontinued due to hypotension, Ticagrelor substituted Prasugrel, and the dose of atorvastatin increase to 80 mg/day as the LDL was 115 mg/dL (Figure 3).

She remained free from angina during a few weeks and complains again of chest discomfort. She discontinued the long-acting nitrate because of hypotension with 1 syncope. Amlodipine 5 mg/b.i.d. is added to the treatment but the complaints remain the same. A stress echocardiogram revealed myocardial ischaemia with inferior wall dyskinesia. A new cath was decided (3rd revascularization) and a
**Figure 3**  ECG and coronary angiogram 9 months after the episode of acute myocardial infarction; coronary angiography showing moderate diffuse coronary abnormalities in the epicardial coronary arteries, subocclusive stenosis at the crux cordis before and after stenting.

**Figure 4**  Flow chart showing the clinical evolution and treatment of the patient.
new stent was implanted in both the RCA and LAD, assuming that there was restenosis.

The patient was able to resume a normal life but 2 months later presented again effort angina. A stress echocardiogram revealed anterior myocardial ischaemia. A new angiogram revealed what was interpreted as mild restenosis in the RCA and LAD that were successfully treated with angioplasty without new stenting.

Three months later she complained again of effort angina. The dose of Amlodipine was increased to 10 mg/b.i.d. and then discontinued because of hypotension. Ezetimibe was added to the treatment for a better control of dyslipidaemia (LDL 70 mg/dL). A new coronary angiogram revealed restenosis of the RCD at the crus cordis. A new stenting was implanted (Figure 3).

The patient continued with chest pain and refused surgical revascularization. Trimetazidine was added to the treatment, and the patient was included in a rehabilitation program. She learned how improve a healthy life style, including diet and exercise. Twelve months after the episode of myocardial infarction, the patient was asymptomatic with a negative stress test exercise echocardiography.

One year later, she remains asymptomatic with the exception of occasional episodes of effort angina (Figure 4).

Comment: The case illustrates the complexity of controlling effort stable angina after an episode of myocardial infarction. Following the guidelines, the treatment is sustained by three pillars: life style, control of risk factors, and anti-ischaemic treatment. The selection of the anti-ischaemic agents depends on the clinical setting, including blood pressure, heart rate, and comorbidities.

Beta-blockers are the first choice in patients with angina after myocardial infarction but were ineffective to control angina. Nitrates and calcium channel blocker were not only ineffective but were also accompanied by hypotension and syncope the reason for their discontinuation. In this particular setting, with low blood pressure and normal heart rate, Ranolazine and or Trimetazidine are the drugs of choice (Figure 5). One can argue if the control of myocardial ischaemia was due to the introduction of trimetazidine, because at the same time the patient was included in a rehabilitation program that could also play an important role.

In this particular case, revascularization procedures were not enough to control myocardial ischaemia and angina.

Consent statement
The patient consent to report the case has been obtained.

Conflict of interest: J.L.L. has received honoraria for steering committee membership from Astra-Zeneca, GSK, Menarini, Merck, Novartis, Pfizer, Sanofi and Servier, as well as speaker honoraria from Amgen and Sanofi, consultancy honoraria from Boehringer, Servier and Menarini. The authors didn’t receive any financial support in terms of honorarium by Servier for the supplement articles.

Reference
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