TABLES

Table 1. High-Risk Conditions and Risk Factors for Cardiovascular Disease			
A. High-Risk Conditions	**B.** Risk Factors for Cardiovascular Disease		
	Underlying Risk Factors	Major Risk Factors	Emerging Risk Factors

Established CHD[a]
 	
Non-coronary forms of atherosclerotic disease[b]
 	
Diabetes mellitus (in high-risk populations)[c]
 	
Multiple risk factors (10-year risk > 20%)[d]
	Atherogenic Diet
	
	Overweight/obesity[e]
	
	Physical inactivity
	
	Genetic factors
		Cigarette Smoking
		
		Hypertension or on treatment for hypertension
		
		Elevated LDL-C[f]
		
		Low HDL-C[g]
		
		Age
		  - Men ≥ 45 years
		  - Women ≥ 55 years
		
		Family history of premature CHD
		
		Hyperglycemia[c]
			Lipid factors
			  - High TG
			  - Small LDL
			  - Apolipoprotein abnormalities
			  - Elevated Lp(a)
			
			Insulin resistance ± impaired fasting glucose or impaired glucose tolerance
			
			Proinflammatory state
			
			Prothrombotic state
			
			Elevated homocysteine
			
			Subclinical atherosclerosis

[a] Established CHD includes history of myocardial infarction, unstable angina, stable angina, and/or coronary artery procedures.

[b] Non-coronary forms of atherosclerotic disease include peripheral vascular disease, abdominal aortic aneurysm, and clinical carotid artery disease (transient cerebral attacks, carotid strokes, and > 50% stenosis of a carotid artery).

[c] Categorical hyperglycemia is a major risk factor for CVD. Moreover, in high-risk populations, patients with clinical diabetes usually have multiple risk factors, and for simplicity of risk assessment, diabetes mellitus can be designated a high-risk condition. This is particularly the case for middle-aged or older patients with type 2 diabetes and for persons of South Asian origin. In some guidelines hyperglycemia counts as a major risk factor in risk assessment; in others, diabetes is designated a high-risk condition.

[d] The 10-year risk for CHD that defines a high-risk state in patients with major risk factors varies by country. This risk level is set at 20% by ATP III for the United States and by European Cardiovascular Societies. However, higher levels (e.g. > 30%) are set in some countries.

[e] In the United States and Europe, overweight is defined as a body mass index (BMI) of 25-29.9 kg/m^2 and obesity represents a BMI of ≥ 30 kg/m^2. Different definitions may be required in other populations to better express the relation between overweight/obesity and CVD risk. For example, obesity is defined as a BMI ≥ 25 kg/m^2 in Asian Pacific countries and Japan.

[f] Definition of elevated LDL-cholesterol (LDL-C) depends on absolute risk of the patient.

[g] HDL-cholesterol (HDL-C) is defined as categorically low by ATP III guidelines as a level < 40 mg/dL (or < 1 mmol/L).

Table 2. Estimate of 10-Year Risk for Men (Framingham Point Scores)

Age	Points	Age	Points	Age	Points	Age	Points	Age	Points
20-34	-9	40-44	0	50-54	6	60-64	10	70-74	12
35-39	-4	45-49	3	55-59	8	65-69	11	75-79	13

Total Cholesterol	Points at Age 20-39	Points at Age 40-49	Points at Age 50-59	Points at Age 60-69	Points at Age 70-79
<160	0	0	0	0	0
160-199	4	3	2	1	0
200-239	7	5	3	1	0
240-279	9	6	4	2	1
280+	11	8	5	3	1

	Points at Age 20-39	Points at Age 40-49	Points at Age 50-59	Points at Age 60-69	Points at Age 70-79
Nonsmoker	0	0	0	0	0
Smoker	8	5	3	1	1

HDL	Points	HDL	Points	HDL	Points	HDL	Points
60+	-1	50-59	0	40-49	1	<40	2

Systolic BP	If Untreated	If Treated
<120	0	0
120-129	0	1
130-139	1	2
140-159	1	2
160+	2	3

Point Total	10-Year Risk	Point Total	10-Year Risk	Point Total	10-Year Risk
<0	<1%	5	2%	11	8%
0	1%	6	2%	12	10%
1	1%	7	3%	13	12%
2	1%	8	4%	14	16%
3	1%	9	5%	15	20%
4	1%	10	6%	16	25%
				17 or more	≥30

Table 3. Estimate of 10-Year Risk for Women (Framingham Point Scores)

Age	Points	Age	Points	Age	Points	Age	Points	Age	Points
20-34	-7	40-44	0	50-54	6	60-64	10	70-74	14
35-39	-3	45-49	3	55-59	8	65-69	12	75-79	16

Total Cholesterol	Points at Age 20-39	Points at Age 40-49	Points at Age 50-59	Points at Age 60-69	Points at Age 70-79
<160	0	0	0	0	0
160-199	4	3	2	1	1
200-239	8	6	4	2	1
240-279	11	8	5	3	2
280+	13	10	7	4	2

	Points at Age 20-39	Points at Age 40-49	Points at Age 50-59	Points at Age 60-69	Points at Age 70-79
Nonsmoker	0	0	0	0	0
Smoker	9	7	4	2	1

HDL	Points	HDL	Points	HDL	Points	HDL	Points
60+	-1	50-59	0	40-49	1	<40	2

Systolic BP	If Untreated	If Treated
<120	0	0
120-129	1	3
130-139	2	4
140-159	3	5
160+	4	6

Point Total	10-Year Risk	Point Total	10-Year Risk	Point Total	10-Year Risk
<9	<1%	14	2%	20	11%
9	1%	15	3%	21	14%
10	1%	16	4%	22	17%
11	1%	17	5%	23	22%
12	1%	18	6%	24	27%
13	2%	19	8%	25 or more	≥30%

Table 4. Estimate of 10-Year Risk (PROCAM Point Scores)

Age	Points	Age	Points	Age	Points	Age	Points	Age	Points	Age	Points
35-39	0	40-44	6	45-49	11	50-54	16	55-59	21	60-65	26

LDL-C		Points
mg/dL	mmol/L	
<100	<2.59	0
100-129	2.59-3.36	5
130-159	3.37-4.13	10
160-189	4.14-4.91	14
≥190	≥4.92	20

HDL-C		Points
mg/dL	mmol/L	
<35	<0.91	11
35-44	0.91-1.16	8
45-54	1.17-1.41	5
≥55	≥1.42	0

TG		Points
mg/dL	mmol/L	
<100	<1.14	0
100-149	1.14-1.70	2
150-199	1.71-2.27	3
≥200	≥2.28	4

Cigarette Smoking (during past 12 months)	Points
Yes	8
No	0

Diabetes Mellitus [Known diabetes or fasting blood glucose levels ≥ 120 mg/dL (6.66 mmol/L)]	Points
Yes	6
No	0

Myocardial Infarction (before age 60y in 1st degree relative)	Points
Yes	4
No	0

Systolic BP	Points
<120	0
120-129	2
130-139	3
140-159	5
≥160	8

PROCAM Score: 10-Year Risk of Acute Coronary Event

Total score	10y risk	Total score	10y risk	Total score	10y risk	Total score	10y risk	Total score	10y risk	Total score	10y risk
≤20	<1.0	27	1.8	34	3.5	41	7.0	48	12.8	55	22.2
21	1.1	28	1.9	35	4.0	42	7.4	49	13.2	56	23.8
22	1.2	29	2.3	36	4.2	43	8.0	50	15.5	57	25.1
23	1.3	30	2.4	37	4.8	44	8.8	51	16.8	58	28.0
24	1.4	31	2.8	38	5.1	45	10.2	52	17.5	59	29.4
25	1.6	32	2.9	39	5.7	46	10.5	53	19.6	≥60	≥30.0
26	1.7	33	3.3	40	6.1	47	10.7	54	21.7		

Table 5. The Metabolic Syndrome	
Risk Factors of the Metabolic Syndrome	**Criteria for Clinical Diagnosis of the Metabolic Syndrome (3 of 5)[a]**

• Atherogenic dyslipidemia
  - Elevated triglyceride
  - Small, dense LDL particles
  - Low HDL cholesterol
• Elevated blood pressure
• Insulin resistance ± elevated glucose
• Proinflammatory state
• Prothrombotic state
	• Increased waist circumference[b]
	• Elevated triglyceride ≥150 mg/dL (≥1.7 mmol/L)
	• Reduced HDL cholesterol
	  - Men <40 mg/dL (<1 mmol/L)
	  - Women <50 mg/dL (<1.3 mmol/L)
	• Elevated blood pressure
	  - Systolic blood pressure ≥130 mmHg or diastolic
	    blood pressure ≥85 mmHg
	• Elevated fasting glucose (≥110 mg/dL; ≥6 mmol/L)

[a] The World Health Organization provides similar diagnostic criteria for the metabolic syndrome, except that it requires the presence of clinical evidence of insulin resistance, i.e. type 2 diabetes, or elevated fasting glucose (≥ 6.0 mmol/L), or elevated 2-hr post-prandial glucose (≥ 7.6 mmol/L). Slightly different criteria on other risk factors also are proposed.

[b] Increased waist circumference is defined differently for different populations. Three examples of population specific recommendations for increased waist circumference are as follows:

	Europe and United States	**Asian Pacific Region**	**Japan**
Men	≥102 cm (≥ 40 in)	≥90 cm	≥85 cm
Women	≥88 cm (≥ 35 in)	≥80 cm	≥90 cm

Table 6. Therapeutic Modification of Atherogenic Diets

• Reduce saturated fats to <7% of total energy[a]
• Reduce dietary cholesterol to <200 mg/day
• Increase viscous fiber, if possible to 10g/day
• Consume at least five servings of fruits and vegetables daily
• Keep intakes of *trans* fatty acids low
• Ensure adequate intake of folic acid (400-1000 micrograms per day)
• Maintain N-3 fatty acid intake (in the form of linolenic acid) to at least 1% of total energy (2-3 g/day). Adding fish-oil N-3 fatty acids (DHA+ EPA) of 1g/day for high-risk patients is recommended in some guidelines but not all (see Table 1 for high-risk conditions). Fish oil supplements for high-risk patients therefore are optional.
• Avoid excessive intakes of alcohol. If alcohol is consumed, limit consumption to no more than 20-30 g of ethanol per day for men, and no more than 10-20 g of ethanol per day for women
• For patients with hypertension
  - Limit alcohol intake to 20-30 g/day for men and to 10-20 g/day for women[b]
  - Limit sodium intake to <100 mmol/day (2.4 g sodium or 6.0 g sodium chloride)
  - Maintain adequate intakes of potassium (90 mmol/day), calcium, and magnesium
• Consider adding plant stanol/sterol (2 g/day) for elevated LDL cholesterol

[a] Recommendations for total fat intake are variable depending on the population. Population-based studies suggest that as long as saturated fat intakes are kept low, varying intakes of carbohydrates, monounsaturated fatty acids, and polyunsaturated fatty acids are compatible with a healthy diet.

[b] Several reports indicate that moderate intakes of alcohol are associated with decreased risk for CVD events.

Table 7. Goals and Principles of Management of Overweight and Obesity

Goals of therapy for overweight persons with CVD risk factors and for obese patients
• At a minimum, to prevent further weight gain
• To reduce excess body weight
• To maintain lower body weight over the long term

Principles of therapy
• Initially introduce a clinical program of weight loss; reduce body weight by 10% in first 6 months of clinical therapy. Clinical strategies of weight loss include a combined program of:
- Dietary therapy: reduce energy intake by 500-1000 kcal/day[a]
- Behavioral therapies to reinforce changes in eating habits[a]
- Physical activity therapy: physician supervision recommended; initially, walk 30 minutes 3 days per week; increase to 45 minutes of more intensive walking 5 days per week
- Optional therapies (special patients at high risk): pharmacotherapy and weight loss surgery
• Enter indefinite clinical program of weight maintenance consisting of dietary therapy, physical activity, and behavior therapy.
• If any weight gain recurs, reinstitute weight loss program
• If a patient fails to achieve weight loss, prevent further weight gain

[a] Consider referring the patient to a dietitian for medical nutrition therapy

Table 8. Goals and Principles of Physical Activity

Goals of therapy
   High-risk patients: Exercise tolerance test to guide exercise prescription
                      When possible, 30 minutes per day of physical activity preferably in medically supervised program
   Primary prevention: Dynamic exercise 30-60 minutes per day 3 to 6 times per week
                      Moderate resistance training at least 2 days per week

Principles of therapy
Dynamic exercise
   • Higher intensity examples: brisk walking, hiking, stair-climbing, aerobic exercise, calisthenics, resistance training, jogging, running, bicycling, rowing, swimming, and sports such as tennis, racquetball, soccer, and basketball
   • Lower intensity examples: include walking for pleasure, walking rather than driving; climbing stairs rather than taking the elevator; gardening, yard work, housework, dancing; and prescribed home exercise
Resistance training
   • 8 to 10 different exercise sets with repetitions with 10 to 15 lbs free weight
   • Target muscle groups: arms, shoulders, chest, trunk, back, hips, and legs

Table 9. Goals and Principles of Clinical Intervention on Cigarette Smoking

Goal of therapy: Complete smoking cessation

Principles of therapy
   • Tobacco dependence is a chronic condition that often requires repeated intervention
   • Because effective tobacco-dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments; at a minimum, all smokers should be counseled on the advantages of smoking cessation and on dangers of continuing to smoke
   • Brief tobacco-dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment
   • Counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation
   • Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking
   • It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting

Table 10. Goals and Principles of Hypertension Therapy

Goals of therapy
- High-risk patients[a]: goal: reduce blood pressure to < 130/85 mmHg
- Uncomplicated hypertension[b]: goal: reduce blood pressure to < 140/90 mmHg

Principles of therapy
- Underlying risk factors should be treated effectively in all persons with hypertension (Tables 6-9)
- Available drugs include diuretics, beta-blockers, ACE inhibitors, angiotensin II receptor antagonists, calcium antagonists, and alpha blockers. All drugs lower blood pressure similarly. Clinical trial evidence for benefit is strongest for diuretics and beta-blockers. Moreover, clinical trial evidence strongly supports the efficacy for ACE-inhibitors and angiotensin II receptor antagonists for reducing CVD events. Many authorities favor use of combined drug therapies at lower doses to achieve blood pressure goals with a minimum of side effects. The following suggests indications for specific antihypertensive agents.
- For persons with uncomplicated hypertension, consideration can be given to using anti-hypertensive drugs when blood pressure is consistently ≥ 140-150/≥ 90-95 mmHg after therapeutic lifestyle changes. Clinical judgment is required for decisions on drug-initiation levels of blood pressure within the range listed above.
- For patients with diabetes and/or renal insufficiency, initiate anti-hypertensive drugs when blood pressure is ≥ 130/85 mmHg
- Beta-blockers should be given priority after myocardial infarction and are useful in patients with angina and tachyarrhythmias.
- Diuretics are particularly efficacious in patients with heart failure and in older patients with systolic hypertension.
- ACE inhibitors deserve priority after myocardial infarction and with heart failure and left ventricular dysfunction. These drugs may be the preferred anti-hypertensive drugs for patients with diabetic neuropathy.
- Calcium antagonists are useful in patients with angina and in older patients with systolic hypertension.
- Angiotensin II antagonists can be used for patients with ACE inhibitor cough. They are an alternative to ACE inhibitors for heart failure.
- Alpha blockers are an alternative anti-hypertensive drug for men with prostatic hypertrophy.

[a] High-risk patients include those with a history of CHD or stroke, multiple risk factors (10-year risk > 20%), diabetes, chronic renal failure, and left ventricular hypertrophy.

[b] Uncomplicated hypertension includes patients with or without risk factors but who are without the conditions listed under [a] above.

Table 11. Goals and Principles of LDL-Lowering Therapy

Goals of therapy
- Primary goal:
    - High-risk patients[a] (10-year risk for CHD >20%)
        LDL goal <100 mg/dL (<2.6 mmol/L)
    - Multiple (2+) risk factors[b]
        LDL goal <130 mg/dL (<3.4 mmol/L)
    - 0-1 risk factor
        LDL goal <160 mg/dL (<4.1 mmol/L)
- Secondary goal: (if TG ≥200 mg/dL (≥2.3 mmol/L): non-HDL-cholesterol <130 mg/dL
    (<3.4 mmol/L)

Principles of therapy (High-risk patients; 10-year risk for CHD >20%)
- All patients should undergo therapy to modify underlying lifestyle risk factors [atherogenic diet, overweight/obesity, and physical inactivity (see Tables 6-8 respectively)].
- If LDL cholesterol is ≥100 mg/dL (≥2.6 mmol/L) consider starting LDL-lowering drugs simultaneously with therapeutic lifestyle changes. The goal for LDL-lowering should be a level <100 mg/dL (<2.6 mmol/L).
- If LDL cholesterol is <100 mg/dL (<2.6 mmol/L) drug therapy is optional depending on clinical judgment. One recent clinical trial indicated CVD risk reduction with addition of an LDL-lowering drug in high-risk patients when baseline LDL cholesterol was <100 mg/dL. Other clinical trials are underway to determine the optimal LDL cholesterol goal in high-risk patients.
- If baseline serum triglycerides are ≥200 mg/dL (≥2.3 mmol/L), the non-HDL-cholesterol goal can be achieved by higher doses of statins or by combined drug therapy (statin + fibrate or nicotinic acid).

Principles of therapy (10-year risk for CHD <20%)[c]
- For patients with multiple (2+) risk factors, employ therapeutic lifestyle changes for at least 3 months before initiating drug therapy in primary prevention (see Tables 6-9). The LDL-cholesterol goal is <130 mg/dL (<3.4 mmol/L).
- For patients with multiple (2+) risk factors and 10-year risk for CHD of 10-20% (moderately high risk), LDL-lowering drug therapy produces substantial reduction in risk when baseline LDL is ≥130 mg/dL (≥3.4 mmol/L). However, whether drugs are allowed in moderately high-risk patients varies in different countries depending on national health care policy.
- For patients with multiple (2+) risk factors, 10-year risk <10%, and LDL cholesterol ≥160 mg/dL, ATP III considers drug therapy allowable to reduce lifetime risk for CHD. However, in many countries, public funds and private insurance cannot be spent on LDL-lowering drugs for lifetime prevention of CVD in persons at lower short-term risk.
- Older patients (≥65 years) benefit from LDL-lowering with significant CVD risk reduction—both CHD and stroke. Clinical judgment is required for appropriate use of LDL-lowering drugs in older patients.
- If 0-1 risk factors are present, persons can be considered to be at lower risk. However, if LDL cholesterol is persistently very high [>190 mg/dL (>4.9 mmol/L)], LDL-lowering drugs are recommended by ATP III to reduce long-term risk. Whether to use LDL-lowering drugs when LDL cholesterol is in the range of 160-189 mg/dL (4.1-4.9 mmol/L) depends on the severity of an accompanying risk factor.

[a] High-risk conditions include established CHD, non-coronary forms of atherosclerotic disease, diabetes, and 10-year risk for CHD > 20%. Diabetes counts as a high-risk condition in high-risk populations, but as a risk-factor in lower-risk populations (see Table 1 for more details of high risk conditions).

[b] Risk factors that modify LDL goals: cigarette smoking, hypertension, low HDL cholesterol (< 40 mg/dL; < 1 mmol/L), advancing age (men ≥ 45 years; women ≥ 55 years). NCEP ATP III includes family history of premature CHD as one risk factor affecting the LDL-cholesterol goal.

[c] Guidelines for this category of risk are based largely on ATP III recommendations. However, indications for LDL-lowering drug therapy for primary prevention when 10-year risk for CHD is < 20% varies according to health-care priorities.

Table 12. **Goals and Principles of Treatment of Low HDL Cholesterol**
Goals of therapy: No specified goal level for HDL cholesterol; however, efforts to raise HDL cholesterol are encouraged.
Principles of therapy • LDL cholesterol is the primary target of therapy in patients with low HDL cholesterol • Controlled clinical trials reveal that statin therapy markedly reduces CHD risk in patients with low HDL cholesterol. • In high-risk patients with elevated triglycerides [200-499 mg/dL (2.3-5.7 mmol/L)], non HDL cholesterol is a secondary target of therapy (see Table 11). • Primary therapy to raise HDL cholesterol includes therapeutic lifestyle changes (see Tables 6-9). • Drugs that raise HDL cholesterol are fibrates, nicotinic acid, and statins. • Controlled clinical trials reveal that fibrate therapy causes moderate reductions in CHD risk in patients with low HDL cholesterol. • Nicotinic acid is the most potent HDL-raising drug and apparently reduces CHD risk.

Table 13. **Goals and Principles of Risk-Reduction Therapies in Patients with Diabetes**
Goals of therapy • Reduce hyperglycemia and maintain glycohemoglobin (HbA1c) levels to ≤7% • Complete smoking cessation • Effectively treat hypertension • Reduce LDL cholesterol • Consider therapy for atherogenic dyslipidemia

Principles of therapy
• Therapeutic lifestyle changes are primary therapies for hyperglycemia and co-existing metabolic syndrome.
• Oral hyperglycemic therapies (metformin, sulfonylureas, thiazolidinediones alone or in combination) usually are required to achieve the glycohemoglobin goal when baseline serum glucose is in the range of 140-180 mg/dL.
• Insulin therapy is usually required to achieve glycohemoglobin goals when fasting glucose is ≥180 mg/dL.
• Patients with diabetes experience significant CVD risk reduction with control of other risk factors
  - Smoking cessation should be stressed in patients with diabetes (see Table 9)
  - Blood pressure should be reduced to goal: ≤130/85 mmHg (see Table 10)
  - According to ATP III guidelines, LDL cholesterol should be treated as indicated for high-risk patients, i.e., the LDL-cholesterol goal is <100 mg/dL (<2.6 mmol/L; Table 11). According to some authorities, however, if the patient with diabetes has an estimated 10-year risk for CHD <20%, an LDL-cholesterol goal <130 mg/dL (<3.4 mmol/L) is acceptable; LDL-lowering drugs need not be considered unless LDL-cholesterol is ≥130 mg/dL in this circumstance.
  - There is growing evidence of benefit with drug therapies for secondary lipid targets, e.g. atherogenic dyslipidemia. For example, elevated triglyceride and/or low HDL can be treated with either a fibrate or low dose of nicotinic acid.

Table 14. Goals and Principles of Clinical Management of Emerging Risk Factors

Goals of therapy: Clinical judgment should be employed on whether to intervene clinically in emerging risk factors. The only exception is the prothrombotic state in which anti-platelet therapy should be employed routinely in higher risk patients.

Principles of therapy
- Metabolic syndrome: primary therapies of the metabolic syndrome (Table 5) are lifestyle changes (Tables 6-8). Secondary therapies include drug treatment for individual risk factors, several of which are emerging risk factors (see below).
- Elevated triglycerides
  - Triglyceride levels 150-199 mg/dL (1.69-2.24 mmol/L): institute weight reduction (Table 7) and increase physical activity (Table 8).
  - Triglyceride levels 200-499 mg/dL (2.24-5.63 mmol/L): goal of therapy: reduce non-HDL cholesterol to 30 mg/dL (0.8 mmol/L) above the LDL-cholesterol goal. When drug therapy is required, consider statins, fibrates, or nicotinic acid.
- Elevated Lp(a): No specific therapy recommended. Some authorities recommend more aggressive lowering of LDL cholesterol.
- Insulin resistance: Primary therapy is lifestyle changes (Tables 6-8). Some authorities employ metformin or thiazoladinediones, although such therapy is not recommended for routine practice. Reduction in CVD risk has not been documented by these agents in controlled clinical trials.
- Proinflammatory state. Several therapies have been reported to reduce hs-CRP and therefore may reduce the proinflammatory state. Among these interventions are weight loss, aspirin, clopidogrel, statins, ACE inhibitors, PPARα agonists such as fibrates, PPARγ agonists such as thiazolidinediones, and nicotinic acid.

Table 15. Goals and Principles of Therapy in Patients with Prothrombotic State

Goals of therapy
- High-risk patients: Institute anti-platelet therapy in high-risk patients in whom therapy is not contraindicated
- Moderately-high risk patients: Consider low-dose aspirin therapy in persons whose 10-year risk for CHD is 10-20% when therapy is not contraindicated

Principles of therapy
- Primary antiplatelet therapy is aspirin 75 to 325 mg/day
- Consider clopidogrel when aspirin is contraindicated. Clopidogrel dose is 75 mg/day.
- Consider warfarin after myocardial infarction when antiplatelet drugs are contraindicated. If warfarin is needed after myocardial infarction, an international normalized ratio of 2.0-3.0 is recommended.
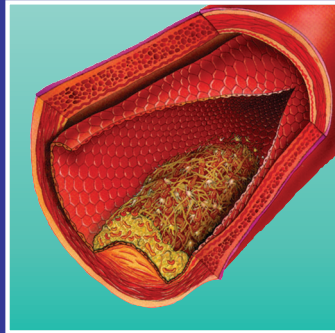
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