Clinical Practice Guideline for the Use of Beta Blockers Post Acute Myocardial Infarction

The use of beta blockers post acute myocardial infarction has been proven to reduce the risk of reinfarction and mortality long-term. A beta blocker should be prescribed and/or continued unless clear contraindications are documented.

The use of beta blockers **may be contraindicated** in the presence of the following disease states or conditions. Physician discretion should be used in treating patients with:

- Insulin dependent diabetes mellitus, history of asthma, heart block >1 degree, sinus bradycardia, decompensated congestive heart failure, and chronic obstructive pulmonary disease with bronchospasm.
- Use cautiously with left ventricular dysfunction with any sign of decompensation and COPD without bronchospasm.

**Practitioners are encouraged to thoroughly document on the patient’s hospital discharge summary the reasons a beta blocker is not prescribed post hospitalization for acute myocardial infarction.**

The following beta blockers are acceptable: The generic name is listed first with the brand name in parenthesis.

- Atenolol (Tenormin)
- Labetalol HCL (Normodyne or Trandate)
- Metoprolol Succinate (Toprol XL)
- Metoprolol Tartrate (Lopressor)
- Nadolol (Cogard)
- Propranolol HCL (Inderal)
- Timolol Maleate (Blocadren)
- Carvedilol (Coreg)
- Acebutolol
- Betaxolol HCL
- Nebivolol (Bystolic)

**The American College of Cardiology recommends that patients who have had a myocardial infarction be treated with a beta-blocker indefinitely (unless the patient has a documented contraindication to beta-blocker therapy or a previous reaction [i.e., intolerance] to beta-blocker therapy).**
References


Chief Medical Officer
Medical Associates Clinic & Health Plans

President
Medical Associates Clinic

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