



**Opinion**

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# Illustration of Disease and Cardiology Treatment



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## Opinion

Translated and Edited by Siti Salmah Ismail, there are five major risks for the development of arterosclerosis and coronary artery disease i.e, men, increased age, smoking, hyperlipidemia and high blood pressure. The last three factors are reversible and can be modified to minimize the risk of coronary potential. Smoking is responsible for the majority of deaths that can be avoided due to coronary artery disease. Quitting smoking reduces the risk and this should be emphasized to every patient who has or has not had coronary artery disease. Increased plasma lipid is often due to a mix of genetic factors (monogenic or polygenic) and environment. Family hypercholesterolemia (FH) has been characterized critically and also at the molecular stage. In this case, the genes encode low density lipoprotein (LDL) receptors that decrease or fail to function until they cause failure of LDL cholesterol from plasma. This causes a rise in plasma cholesterol eg: 8-15 mmol / 1 in heterozygote (estimated 1/500) associated with the initial existence of the cornea, xanteloam, xanthomata and coronary artery. The homozygos form (estimated 1 000 000 000) leads to an increase in excessive cholesterol eg 15-30 mmol / 1 and sudden plum xantoma with lipid stains in the aorta and cause aorta supralvalva as well as the first coronary artery disease described at the stage of childhood- children. Other forms of hyperlipidemia are characterized by different biochemical profiles, although rare.

High blood pressure is a powerful free risk factor for coronary artery disease. Unfortunately, in moderate or mild hypertension, studies on drug treatment have failed to show a reduction in myocardial infarction risk even though the risk of stroke is reduced. Angina pectoris is a symptomatic manifestation of myocardial ischemia and is caused by obstructed coronary artery disease. Coronary narrowing due to atheroma is the most common cause

of pectoris angina and the symptoms appear when the lesions in the coronary artery become critical usually > 70% stenosis. Pathology studies however emphasize that despite the presence of critical lesions, patients can become asymptomatic with initial manifestations of sudden death. Angina is most often described as an obsolete central substrate pain and creates up to the jaw and left arm. The most important feature of history is exercise. The rapid revolution of Simon when it comes to stress or even sublingual nitroglycerin is often the most important diagnostic indicator. However, a critical diagnosis is not easy by referring to a common chest pain and is often difficult to distinguish from actual angina. The main indicator of exercise electrocardiography is to assist the diagnosis of patients with chest pain signs that may experience coronary disease, to assess the level of coronary artery disease and subsequent patient prognosis showing a clear diagnosis.

Superiority of all patients under 60 years old and older patients with a history of coronary artery disease should perform an exercise test. Stratification risk following myocardial infarction. Maritimization of the patient with palpitation is triggered by pressure. Most patients are able to do enough exercise to get clinically useful results. Very neat supervision should be noted in unstable coronary disease, severe aortic stenosis or pulmonary hypertension. Exercise or exercise tensions using intravenous dipyridamole or dobutamine are used to trigger ischemia. The test can distinguish ischemic tissue from normal tissues through the isotopes scattered by gamma cameras. Reversal also allows investigations to differentiate myocardial ischemia (reverse defects) from myocardial infarction (non-reversible defects). For patients suffering from angina pectoris and dubious investigations, arteriography is the only method that can interpret diagnosis.



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