INTRODUCTION

The annual mortality from cardiovascular disease in general population is greater than from all other diseases combined. Similarly, the leading cause of death perioperatively is myocardial ischaemia or serious dysrhythmia(**Shah et al., 1991).**

The incidence of perioperative myocardial infarction with noncardiac surgery varies by the type of procedure and prevalence of coronary astherosclerosis(**Ashton, 1994).**

Silent myocardial ischaemia has been called the silent killer.Pain does not kill patients with coronary heart disease, but ischaemia does, whether it happens to be painful or silent(**Hedma, 1994).**

Preoperative evaluation of patients who might have coronary heart disease seeks to assess the patients in two ways:

-First, it is important to estimate the historical predictors which include age, previous myocardial infarction, angina, congestive heart failure, dysrhythmias, valvular heart disease and previous coronary angioplasty.

-Second, it is essential to assess the functional status of the coronary circulation using diagnostic testing predictors as twelve-lead ECG, exercise stress, radionuclear imaging, cardiac catheterization and transoesophageal echocardiography(**Mangano, 1990).**

Intraoperative factors also appear to affect the outcome substantially, independent of the disease status. It is recently recognised that dynamic events occurring intraoperatively may cause perioperative cardiac morbidity, including hypotension,

hypertension, tachycadia, myocardial ischaemia, ventricular dysfunction and arrhythmia**(Edward et al., 1994).**

The possibility of CAD should be considered in patients over 50 years old coming for surgery especially in patients with strong family history of CAD, heavy smokers, and those with elevated blood pressure, elevated serum cholesterol and elevated blood sugar level. Patients in this category as well as patients with definite disease must be fully evaluated and prepared prior to surgery. The postoperative period is the most critical. Myocardial infarction or reinfarction is more prone to occur within the first 72 hours postoperatively than is intraoperatively**(Rao et al., 1983).**