
Cardiac Rehabilitation Underutilised by Clinicians



Cardiac rehabilitation (CR) is a valuable treatment for a broad spectrum of patients with heart disease. Its use is supported by a robust body of research demonstrating improvements in cardiopulmonary fitness, psychological factors, and quality of life and reductions in morbidity and mortality. Despite this evidence, the value of CR is underappreciated and underutilised by many clinicians to the detriment of patient outcomes, says a new study in the journal *Trends in Cardiovascular Medicine*.

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CR has evolved from exercise only into a comprehensive programme that also addresses other cardiovascular disease risk factors and provides education and social support. CR classically consists of three phases: Phase I refers to inpatient rehabilitation during the index hospitalisation; Phase II is the physician supervised, outpatient monitored physical activity during the four months after discharge; and Phase III is an enduring unmonitored exercise programme. Exercise training increases peak oxygen consumption and endurance capacity or the ability to maintain physical activity for extended periods of time.

Moreover, exercise training has multiple other potentially beneficial effects including improving endothelial function, myocardial flow reserve reducing smoking, body weight, blood lipids, and blood pressure. Exercise training has even been shown to reduce the progression of coronary atherosclerosis in patients with known coronary artery disease (CAD).

CR programmes also provide nutritional, psychological and smoking cessation counselling, as well as lipid and blood pressure management. Medicare and most insurance carriers provide coverage for this service after acute coronary syndrome, percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG), valve surgery, and chronic stable heart failure with reduced ejection fraction (HFrEF).

CR can also reduce depression and anxiety and increase quality of life in cardiac patients. In one study, depression symptoms and mortality decreased by 63% and 73% among depressed patients after CR compared to non-participants.

CAD is the most common referral diagnosis to CR centres. The American Heart Association (AHA) and American College of Cardiology (ACC) recommend the referral of patients after myocardial infarction (MI) or coronary revascularisation and those with stable angina to CR because multiple meta-analyses have demonstrated that CR reduces mortality in patients with CAD. On the other hand, cardiac transplant patients represent a small portion of those referred for cardiac rehabilitation. This is because cardiac transplant patients are typically profoundly deconditioned due to their pre transplant severe heart failure, prolonged hospital course, and side effects of immunologic therapies, the journal study explains.

"Available data and guidelines strongly support the role of comprehensive CR in patients with heart disease. Patients benefit from decreased mortality, morbidity, disability, and increased quality of life. CR patients also benefit from reduced hospitalisations, an increasingly important measure as healthcare moves towards a capitated environment," the study notes. "Despite this, only 14% of patients after AMI and 31% in patients after CABG participate in CR. Future studies should focus on how to include more cardiac patients in CR."

The study also says that efforts are needed to overcome the social, economic, and practice behaviours to referral, enrolment, and adherence to CR such that the clinical benefits are attained.

In view of a geographic non-availability of CR programmes for some patients, hybrid home CR programmes are also being developed, the study adds.

Source: [Trends in Cardiovascular Medicine](#)

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