INTEGRATIVE REVIEW ARTICLE

INTERFERENCES AND INTERVENTIONS AFTER ACUTE MYOCARDIAL INFARCTION: AN INTEGRATIVE REVIEW OF THE LITERATURE

INTERFERÊNCIAS E INTERVENÇÕES PÓS-INFARTO AGUDO DO MIOCÁRDIO: REVISÃO INTEGRATIVA DE LITERATURA

LAS INTERFERENCIAS E INTERVENCIONES DESPUÉS DE UN INFARTO AGUDO DE MIOCARDIO: UNA REVISIÓN INTEGRADORA DE LA LITERATURA

Vicente Alves de Oliveira Júnior[1], Mariana Pereira Hamaji[2], Fernando Henrique Sousa[3], Carla Aparecida Pinto de Sousa[4], Vitor Engrácia Valenti[5]

ABSTRACT

Objective: to identify the interference of acute myocardial infarction (AMI) in the quality of life of affected, interventions and understanding by health professionals. ***Method:*** an integrative review, aiming to answer ***<< What are the interference in the quality of life of post-AMI customers? >> and << What are the interventions proposed in order to minimize them? >>***. We selected 12 articles available in the LILACS database, between 2000 and 2011, based on the criteria of inclusion and exclusion. ***Results:*** we have selected a total of 12 articles selected according to the inclusion and exclusion criteria pre-established. We obtained a classification into two themes (1) interference with quality of life and (2) proposals for interventions to minimize interference. ***Conclusions:*** highlights the importance of patient involvement in care plan well structured, multidisciplinary team integration and quantity of publications by heterogeneous country on the subject. ***Descriptors***: Myocardial Infarction, Quality of Life; Lifestyle.

RESUMO

Objetivo: identificar as interferências do infarto agudo do miocárdio (IAM) na qualidade de vida dos acometidos, as intervenções e sua compreensão pelos profissionais de saúde. ***Método:*** revisão integrativa, objetivando responder ***<< Quais as interferências na qualidade de vida dos clientes pós IAM? >>*** e ***<< Quais as intervenções propostas com vistas a minimizá-las? >>***. Selecionou-se 12 artigos disponíveis na base de dados LILACS, entre 2000 e 2011, baseado nos critérios de inclusão e exclusão. ***Resultados:*** foram selecionados ao todo 12 artigos selecionados de acordo com os critérios de inclusão e exclusão pré-estabelecidos. Obtivemos um classificação em dois temas (1) interferências na qualidade de vida e (2) propostas de intervenções visando minimizar as interferências. ***Conclusão:*** destaca-se a importância do envolvimento do paciente no plano de cuidado bem estruturado, integração da equipe multiprofissional e quantidade de publicações heterogênea pelo país sobre o assunto. ***Descritores:*** Infarto do Miocárdio; Qualidade de Vida; Estilo de Vida.

RESUMEN

Objetivo: identificar la interferencia de infarto agudo de miocardio (IAM) en la calidad de vida de los afectados, las intervenciones y la comprensión por los profesionales de la salud. Método: revisión integradora, con el objetivo de responder a ***<< ¿Qué es la interferencia en la calidad de vida de los clientes post-IAM? >>*** y << ***¿Cuáles son las intervenciones propuestas con el fin de minimizarlos? >>***. Se seleccionaron 12 artículos disponibles en la base de datos LILACS, entre 2000 y 2011, con base en los criterios de inclusión y exclusión. ***Resultados:*** se han seleccionado un total de 12 artículos seleccionados de acuerdo con los criterios de inclusión y exclusión previamente establecidos. Se obtuvo una clasificación en dos temas (1) interferencia con la calidad de vida y (2) las propuestas de intervenciones para reducir al mínimo la interferencia. ***Conclusiones:*** destaca la importancia de la participación del paciente en el cuidado plan bien estructurado, la integración del equipo multidisciplinario y la cantidad de publicaciones por país heterogéneo sobre el tema. ***Descriptores***: Infarto de Miocardio; La Calidad de Vida; El Estilo de Vida.

[1]Nurse, Faculty of Medicine of Marília/FAMEMA. Marília (SP), Brasil. Email: vicentealves_@hotmail.com; [2]Nurse, Faculty of Medicine of Marília/FAMEMA. Marília (SP), Brasil. E-mail: marihamaji@hotmail.com; [3]Physiotherapist, Master in Psychology/FC-UNESP/Bauru, Bauru (SP), Brasil. E-mail: drfhs@yahoo.com.br; [4]Occupational Therapist, Federal University Paulista/UNIFESP Baixada Santista, Santos (SP), Brasil. E-mail: carlaparecid@yahoo.com.br; [5]Physiotherapist, Postdoctoral-FM/University of São Paulo/USP, Ph.D., Assistant Professor, Department of Speech Pathology/FFC-UNESP/Marília. Marília (SP), Brasil. E-mail: vitor.valenti@gmail.com

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INTRODUCTION

Cardiovascular diseases are the leading cause of death and disability in Brazil and worldwide. In Brazil, cardiovascular diseases are responsible for at least 300,000 deaths annually, and have a more expensive treatment than any other condition and represent the highest costs of pensions and retirement allowances with antecipadas.[1] The risk of death in 2006 was approximately 149.4 cases per 100 thousand inhabitants, representing a reduction of 1.4%, according to latest pesquisas.[2] In 2005, there were more than 1.1 million hospitalizations due to cardiovascular diseases in Brazil, resulting in financial cost approximately R $ 1.32 billion.[3] Through the data presented, cardiovascular disease require special attention from health professionals, among these diseases highlight the acute myocardial infarction (AMI).

Some factors are known to be related to AMI (acute myocardial infarction d), such as smoking, high levels of LDL cholesterol, low HDL, melitos diabetes, hypertension, family history, physical inactivity, central obesity, metabolic syndrome and abuse of alcohol, as they give the appearance of atherosclerotic plaque.[4] AMI occurs after mobilization of an atherosclerotic plaque, causing a significant reduction in blood flow to the coronary artery by thrombus formation or spasm. Consequently angina may occur or even death súbita.[5] studies relate the incidence of AMI socioeconomic status of the population, since their increased involvement relates to lifestyle adverse lower classes, such as inadequate nutrition and sedentarismo.[6]

After the onset of AMI show up some interference, as customers begin to review their life values, and show signs of anxiety and decreased self-esteem. These facts may result in a feeling of inability of natural activities, leading to personal and marital dissatisfaction, and the latter may cause damage to the intercourse casal.[7]

Given these interferences, there are implications for the disruption and fragmentation of the interactions, activities, relationships and thoughts that gave meaning to his life up to that point, going to live due attention to their new condition, which results in the interaction with the fear of Death. Therefore, customers experience much suffering the symptoms as fear of death.[8] this way, the customer is presented interference in biological functions, social, psychological. These changes affect significantly the quality of life (QOL) of these clients.

The quality of life is one of the most important indicators for evaluative conclusions intervencionistas.[9] Thus, the analysis of affected customers with AMI these indicators are valuable for understanding the changes in your life, the health professional may adopt interventionist actions such such as health education, social support, diet control and medicines, among others, that will result in minimizing the implications of post-AMI. These should be given in a unique way, encompassing all health needs of the customer.

To provide this improvement in the comfort and well-being of the client affected AMI, it is necessary to implement the promotion, maintenance and restoration of health, increasing their quality of life. Interventions should include the client as a whole, involving the biological, psychological, social and cultural rights, including, in this way, the health needs of the subject, performing a singular intervention plan, which will provide a better quality of life of the customer after AMI. Within this intervention plan some actions are highlighted: the understanding of the subject opposite the pathology and the consequences of this in your life.

For the present study, we aimed to identify the scientific interference of acute myocardial infarction (AMI) in the quality of life of affected, interventions and understanding by health professionals.

METHOD

It is an integrative review, where the theme refers to the quality of life of individuals affected by AMI. In order to guide the research, formulated the following questions: What are the interference in the quality of life of clients who have suffered AMI? What are the interventions proposed in order to minimize them? Therefore, this work aimed to identify the scientific interference of acute myocardial infarction (AMI) in the quality of life of affected, interventions and understanding by health professionals.

In this type of research the reviewer aims to make a critical selection of texts and evaluate the criteria and methods used by the authors to determine the methodological validity, which causes the reduction of the number of surveys included in the final stage of the review. It aims to achieve this methodology with a deep knowledge about the given topic, defining clearly the presentation of results obtidos.[10]

The development of this integrative review, we used six distinct steps: identifying the topic and research question to conduct

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the review; establishing criteria for inclusion and exclusion of articles; definition of the necessary information; evaluation of full texts, and interpretation of results eat conclusão.[10]

The survey was conducted from February to March 2012, where it was used as inclusion criteria the articles published between 2000 and 2011 who answered the guiding questions, only in Portuguese. It was considered as an exclusion criterion items not involved in the thematic objective of this study and publications Masters.

For select descriptors carried out a consultation with DECS (Descriptors in Health Sciences), resulting in: "myocardial infarction" and "quality of life" and or "lifestyle."

The search was performed by the database of the Latin American and Caribbean Health Sciences (LILACS), totaling 59 publications. Subsequently, we selected publications that met the inclusion and exclusion criteria previously defined, resulting in 12 articles for analysis.

Selected articles were arranged in Figure 1.

After selection of items based on the criteria of inclusion and exclusion, began reading the abstracts and full texts of the later aiming to answer the guiding questions.

For data collection, was tabbed the following categories of items: author and his training, title, type of study, purpose, year of publication, place of study, gender of respondents, interference AMI in routine and interventions.

For data evaluation aspects were observed that responded the guiding question, the aspects that affect the quality of life, team performance and type of study. The presentation and discussion of the results is given from the descriptive analysis of these data (Table 1 and results). All items remained the impartiality of results, discussion and conclusions.

RESULTS

Author	Title	Objective	Type of study
1.Mussi FC.	The infarct and break with everyday life: possible role in prevention of nursing.	Examine perceptions of hospitalized patients after AMI.	Qualitative study.
2.Benetti M, et al.	Changes in quality of life in coronary patients suffering from acute myocardial infarction undergoing different treatments.	Compare the QOL of patients after AMI in different treatments	Cohort comparative study. retrospectivo.
3.Mussi FC.	Discomfort, biomedical and nursing: reflections on the experience of infarcted men.	Reflect on the dimensionality of the intervention hospital medical patient after AMI.	Theoric reflexion.
4.Souza NS, et al.	Predictors of change in quality of life after an acute coronary event.	Recognize predictors of QOL of patients with a coronary syndrome.	Qualitative study.
5.Alcântara EC, et. al.	Assessment of quality of life after acute myocardial infarction and its correlation with the risk factor.	Note change in QOL after AMI.	Descriptive and cross-sectional quantitative approach study.
6.Nogueira CSR, et al.	Quality of life after coronary artery bypass grafting with and without cardiopulmonary by-pass.	Confronting QOL of patients who underwent surgery and did not undergo cardiopulmonary bypass.	Quanti-qualitative study.
7.Lemos C, et al.	Association between depression, anxiety and quality of life after myocardial infarction.	Compare frequency of depression in patients after AMI hospitalized and outpatients.	Qualitative study.
8.Lunelli RP, et al.	Sexual activity after myocardial infarction: taboo or misinformation.	Describe the knowledge of patients after AMI and received guidance regarding sexual intercourse.	Transversal study.
9.Vacanti LJ, et al.	Age and psychological disorder: factors associated with sexual dysfunction in post-infarction.	Studying the emergence of sexual dysfunction after AMI.	Qualitative study.
10.Melo EC, et al	Acute myocardial infarction in the city of Rio de Janeiro: data quality, spatial distribution and survival	Analyze quality of information on deaths from myocardial infarction, patient survival and spatial distribution of mortality in RJ.	Qualitative study.
11.TakiutiME, et al.	Quality of life after coronary artery bypass surgery, angioplasty or medical treatment	Assess QoL in multifactorial disease undergoing coronary treatments.	Qualitative study.
12.Gallani MCBJ, et al.	Quality of life in patients with coronary artery disease	Evaluate patients with previous myocardial infarction angina prectoris related QOL.	Descriptive non-experimental study.

Figure 1. Description of selected articles.

Of selected articles that met the inclusion criteria previously established, prevailed publications in 2008 with four publications, followed by 2007 with three, with two 2003, 2001, 2004 and 2005 with a publication each.

The 12 studies were conducted in the following cities: three studies (25%) in Sao

Paulo, three (25%) in Porto Alegre, two (16.6%) in Rio de Janeiro, two (16.6%) in Salvador, one (8.33%) in Santa Catarina and one (8.33%) in Goiania. Thus the Southeast was the one that had the greatest number of studies with five (41.66%), followed by the South with four (33.33%), with two Northeast (16.66%) and Midwest with a (8.33%). There was no research analyzed in the North of the country.

The papers presented, the professionals that most nurses were published in 6 (50%), followed by 2 physicians (16.66%), physiotherapists 2 (16.66%) and 1 psychologist (8.33%) . Regarding the titrations of these professionals, 5 (41.66%) were teachers, 4 (33.33%) graduates and 3 (25%) doctors.

The studies covered a total of 1259 clients with 877 (69.66%) males and 382 (30.34%) females. From the perspective of interference in routine caused by AMI, 7 articles worked this theme, and 4 in physical appearance, 6 in the psychological aspect and the social aspect 2. Some studies worked simultaneously two or more aspects. In what concerns the interventions adopted, the 8 articles have referred.

DISCUSSION

From the analysis of the selected articles we noted several interference on quality of life associated with biological, psychological, social and cultural factors.

In the biological aspect there is occurrence of limitations triggered by fatigue, shortness of breath and angina. These limiting factors are considered by customers as limiting their habitual activities.[8,11,12]

These symptoms may be associated with the specified client or to other causes other than health problems, characterizing a process of denial of AMI. This may aggravate the clinical condition of the subject, bringing the need for more complex care.[8]

Sexual intercourse was considered as physical activity by demonstrating that it interfere QOL.[11,13] A limitation of intercourse occurs because the client presents exhaustion, change in libido, depression, helplessness, worry or anxiety spouse, feelings of guilt, cardiac complications, fear of death or reinfarction, besides the fear of dyspnea and angina,[11] which represents an incidence of 24% to 89%.[13]

It appears that after the onset of AMI customers returned to the sexual act in approximately 15 days. However, 9.3% of patients did not return to sexual activity after 6 months.[13]

It was shown that 60% of customers had questions regarding the resumption of sexual activity. Intercourse after AMI is an issue addressed in the literature, however, in clinical practice it is not discussed.[11]

Other limitations that affect the QOL occur by decreased general health, vitality, social and mental health that are impaired.[12]

Commonly psychosocial factors are considered secondary in clinical practice, however, the literature states that these factors contribute to the onset of AMI and clinical decline. Thus, highlighting the importance of the psychosocial approach to this context.[14]

Among the 12 articles studied 6 cited this theme. Whereas, 66.7% have as interference cause anxiety and depression.

Depression is not necessarily triggered by the AMI as it can show up even before the present admission of some customers, achieving a significant increase in the same post AMI. Customers under 50 years old and anxious are more likely to develop depression.[15]

Comparing the literature involving clients who suffer from depressive symptoms and those who are not depressed it was found that the risk of patients with depressive symptoms undergo a multivessel coronary disease (CAD) that is consistent with the risks of obesity and also with the smoking habit , which is the biggest risk factor.[16]

Depression was evident in much of the outpatient group, with 53.1%, and lowest in the external control group, with 20.3%. This pathology is an important aggravating risk factor in patients with CAD. It is estimated that these diseases are the major cause of death in 2020, and the combination becomes one concerning factor.[15]

Depression is also mentioned as a cause of impairing the QOL, being associated as a cause of the decrease sexual activity.[11,13]

It may be seen that interference is links the physiological to the psychological aspect, because symptoms such as angina, arrhythmia and fatigue become significant markers in the patient's life. As a result customers experience great suffering, which affects their mental health, which may result in consequence of a new AMI.[12]

It was observed that patients with AMI patients are usually not diagnosed as depressed, this fact is the lack of importance given to the symptoms presented by professionals, because these are considered momentary and "natural", there is also a lack

of knowledge of those involved in the care of this risk factor associated with post AMI.[14,15]

The fear of death is cited as an obstacle in their lives and changing the world view of the customer, to relate to the loss of individual usual activities after AMI, because many of these are dependent terceiros.[8,13,15]

In the social aspect, the tension in the workplace and lack of social support are identified as the major factors affecting the quality of life of clients suffering from AMI. Other factors that might compromise QOL are the losses of loved ones, unemployment, existence of chronic disease in the family or individual, marital problems and problems with suns.[14,16]

We believe that external factors may interfere the person directly on the disease process and worsening the client health, leading to decrease of the same vitality, contributing to decreased QOL.[12]

As regards the cultural aspect, only one author has addressed the issue. The client affected by AMI feels limited continuous actions of everyday life. These limitations have major implications in males because they tend to underestimate the symptoms and refuse medical preventiva.[8]

Given the necessity of implementing the interventions, we had highlighted health education. Health education covers the need for health professionals to implement educational activities relevant to times when demand, including physical, emotional and benefits of control of risk factors, taking into account health needs and involving the active participation individuals considering their survival and how to give their quality.[8, 13,17] Therefore, we emphasize the need for community health programs encompass in different groups.[8]

The qualified professional and expert prepare a program of health education. In this sense it is portrayed the importance of implementing training programs for people with chronic heart disease (CHD) and their families, and to include joint development of an emergency action plan at home and work.[8,14] This program should address the entirety of the subject, with a view to improving QOL.

The adoption of preventive measures and information campaigns for the population about risk factors and clinical manifestations of AMI, are indicated in the study as crucial in shortening the time from symptom onset to arrival at medical answering service, providing the benefits to the patient early treatment.[18]

We may not fail to mention the importance of understanding customers after AMI to their own health needs because, normally, in clinical practice this vision is only part of the trader. The perception of care by the client along with the qualified professional is indispensable since both will build a plan of care, addressing all the customer needs to occur to improve QOL.

For a multidisciplinary successful, with clinical practice and their actions with effective results in quality of life after AMI, it requires the action of a body of qualified and specialized professionals.[19]

In nursing, it is essential to recognize the possible complications related to the AMI framework, to which it must establish clinical reasoning of this situation for the prompt attention to emergency cases.[20]

Similarly, the interventionist measures of qualified and specialized professionals, stimulating environment, relaxed and harmonious relationship between client / professional are extremely relevant.[21]

The performance of a qualified professional to detect the vulnerable population with AMI results in its effective prevention.[8,11,15]

In the physical aspect, it was proposed to carry out regular exercise, consisting of five repetitions for 15 minutes, improving their physical and mental after catheterization and after coronary artery bypass graft.[16, 17,21]

In order to implement this practice and make a habit of life for patients after AMI, it is necessary to study public policy to accompany them during the period of rehabilitation, and adoption of approaches to motivate physical exercises.[22]

It was portrayed in the study of interventions important health professionals, guided psychosocial processes and health promotion aimed to an comprehension of the individual as a whole, as one of intervention measures in the social aspect.[14]

Other interventionist measures were cited as the medication and proper diet as well as the periodic control of serum cholesterol. It emphasizes the importance of patients knowing the side effects of medications, as well as the adoption of measures regarding the healthy habits.[23]

The social aspect also is present in view of the breadth of the country, where the case of a developing country is its social and economic inequalities characteristic between regions, as well as access to health and development of the population, reflecting morbidity and mortality patterns due to AMI.[24]

We may say that the QOL of these clients is entirely related with a good plan of care, as this is done in a unique and integral lead to an improved perspective of life.[16]

Coupled with adequate knowledge management professionals at this clientele, the physical structure welcoming gives users the minimization of the consequences generated by AMI.[25]

CONCLUDING REMARKS

It was shown that the performance of the multidisciplinary team in the promotion and rehabilitation is being held in a fragmented manner, taking into consideration only curative, and, excluding the customer in participatory action of his improvement. We mentioned the eating habits, medication, social support, understanding the factors involved in AMI and exercise as interventions that provide a better QOL for clients. The psychological aspect did not explicitly show any intervention measure in the works analyzed. Thus, we emphasize the importance of stimulating the production of scientific papers by other health areas in this issue, since it fosters multidisciplinary analysis of the QOL of the client.

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Corresponding Address

Vicente Alves Oliveira Júnior
Rua Belo Jardim, N 597
Bairro Santa Clara
CEP: 07123-100 – Guarulhos (SP), Brasil