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Editorial Open Access

Cardiac Rehabilitation in Patients after Acute Myocardial Infarction

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Editorial

Cardiac rehabilitation (CR) for patients after acute myocardial infarction (AMI) is recommended by practice guidelines, and includes multifaceted interventions to improve atherosclerotic risk markers, lifestyle, exercise capacity, quality of life, increases life expectancy, suppresses hospitalization frequency in patients with cardiovascular disease and has been shown to be cost-effective. CR programs include individualized exercise regimens, structured support focused on cardiovascular risk reduction, health education, nutrition counseling, psychosocial and vocational support, and medication adherence [1-3].

The exercise test provides for the appropriate training intensity prescription by heart rate reserve (40%–80% of peak), O_2 reserve (40%–80% of peak), percent of peak exercise heart rate achieved (65%–80%), and rating perceived exertion (11–16 on a 6-to-20 Borg scale), the exercises are performed below the ischemic threshold [4-6]. The CR should include endurance activities, balance, coordination, flexibility and stretching. Patients typically attend 2 to 5 sessions weekly for 30 to 60 minutes with up to 36 to 40 sessions. The components of each session should contain heating and cooling periods with duration of 5 to 10 minutes each, with field or walking on the treadmill. Strengthening exercises may be performed 2 to 3 times per week with 6 to 15 repeats per muscle group at intervals of 30 seconds to one minute, with intensity 40-70% of maximal voluntary contraction, reaching 5 series 10 repetitions with 70-80% of maximum voluntary contraction. Exercise prescription should be individualized according to clinical condition of the patient taking into account the individual limitations or comorbidities (orthopedic, neurological, respiratory, nephrology, infectious, among others) [4-7]. Adherence methods of the CR program should be implemented in this population towards a lower morbidity and mortality as well as a reduction in spending on hospitalizations.

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