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Medical Art Refer to as Preventive Cardiovascular Disease

Yun Zhing*

Department of Cardiology, Taizhou Hospital Affiliated to Wenzhou Medical University, Linhai, Zhejiang Province, P.R China

Introduction

The idea that preventative measures lower the risk of cardiovascular disease (CVD) is straightforward but challenging to put into reality. The pillars of maintaining cardiovascular health are quitting or avoiding smoking, eating sensibly, controlling weight, exercising frequently, managing stress, and checking blood pressure, cholesterol, and sugar levels frequently. The epidemic of (CVD) that we continue to face is primarily explained by the fact that these deceptively basic action items are frequently ignored by the general public and poorly handled by their practitioners. Only 5% of patients with a BMI over 30 were classified as obese anywhere in the electronic medical record in a primary care setting, according to a recent study, and another study revealed that Familial Hypercholesterolemia, the most severe and common form of hypercholesterolemia, only affects 1% of patients. CVD will continue to be the dominating determinant determining our life expectancy until we take action and scale up management techniques for its risk factors and co-morbidities. To dramatically improve this projection, several coordinated efforts are needed, the most crucial of which is the development of a specialised subspecialty focused on CVD prevention [1].

Description

The medical community and general public will need to be made aware of the existence of this service and frequently use it for risk assessment after preventive cardiology has been formed as a distinct speciality of cardiovascular medicine. Additionally, hospitals must incorporate this service and make it as common as general cardiology or general endocrinology clinics. As integrated elements of internal medicine, endocrinology, cardiology, nephrology, women's health services, cardiac rehabilitation facilities, medical genetics, and most importantly as free-standing lipid clinics, pieces of the medical art that we refer to as preventive cardiology have a long history. However, since present efforts are scattered, fragmented, non-standardized, and unaccredited by a professional board, a thorough and unified description and organisation of preventive cardiology services still needs to be developed (with the exception of the sub disciplines of Clinical Lipid ology and Obesity Medicine). Preventive cardiologists' first generation should emerge from a professional and educational system akin to those in existence for other subspecialties. A preventive cardiologist should be held to the same high standards that we hold interventional cardiologists to, regardless of where they received their training or where they currently practise. Nevertheless, it is likely that the experiences of any patients seeking guidance for the assessment and management of CVD risk would differ significantly from one location to another, from one hospital to another, or even from one practise to another within the same town. It's crucial to remember that no change in the way healthcare is organised and provided will completely solve an issue whose causes are endemic to society and exacerbated by economic inequalities. The foundation for our interventions is access to clean air, affordable and safe healthy food, and living in a setting that supports wellbeing, yet these are all out of reach for even the most devoted caregiver. Our lawmakers must support public health and health system initiatives, and they must persuade health insurance providers to cover fully the relatively low-cost diagnostic tests and pharmaceutical therapies that have the potential to halt the heart attack epidemic [2].

Our knowledge of the causes of atherosclerosis has grown increasingly thorough and sophisticated during the past 60 years. The Framingham Heart Study (FHS), a prospective population cohort observational programme, was made possible by the NIH in an effort to identify the variables associated with the onset of atherosclerotic CVD (ASCVD). We formed the present understanding of ASCVD from this study, which is that it is a complicated, multifactorial, slowly increasing degeneration of the arterial wall that result in occlusion by either blockage or superimposed thrombosis. The Framingham investigators invented the phrase "risk factor" for coronary heart disease, which is crucial to the diagnosis, avoidance, and care of ASCVD. As FHS amply demonstrated, multiple factors coexist and work together to accelerate the path to disease development, the knowledge that dyslipidemia, hypertension, diabetes, smoking, inheritance, and stress are linked to ASCVD marked an inflection point in the interest to study risk factor management and to provide preventive services to lessen the burden of ASCVD. The key findings from the FHS have been replicated in many cohorts from around the world, indicating that the determinants governing atherosclerosis susceptibility are not based on ethnicity, race, or gender [3].

Since many of these risk variables are ubiquitous, acquired, and adjustable, they can be incorporated into risk assessment algorithms to properly stratify patients and track therapy effectiveness. These discoveries led to the emergence of a network of lipid clinics in the US and other countries. Most of these initiatives served as research institutes for lipid metabolism studies, clinical trials of lipid-lowering medications, and the care of people with genetic diseases such Familial Hypercholesterolemia. The globe is now adjusting to the COVID19 outbreak as this piece is being published. At this time, neither we nor our nurses are able to meet in person with non-urgent patients. We are concerned about our future as authorities on chronic, non-infectious disorders as well as our own physical well-being. Is preventive cardiology being demoted to a minor, optional medical specialisation at this point? On the contrary, now is the perfect opportunity for us to demonstrate the worth of our knowledge, our actions, and our results [4].

The difficulties are obvious: The coronavirus outbreak may seem to be telling us to "ubi maior minor cessat step aside, chronic disease managers, because all we need is ventilators!" But the benefits of skilled CVD prevention are obvious: We address three issues, such as the current debate over whether ACE-I or ARB should be discontinued if they are actually affecting the entry point of the COVID19 virus within cells, in order to: 1. mollify the co-morbidities that make the epidemic so much more dangerous; 2. be on the front lines of the fight against the increased CVD risk brought on by the enormous financial, societal, and psychological stress of this crisis; and 3. combat these issues. 4. By advancing telemedicine, we create the door for an outpatient visit structure that is more contemporary and genuinely advance preventive cardiology to a scalable, sustainable, and effective platform. Preventive cardiology is the field that strives to help you confront life problems with a strong heart. As we eventually put this epidemic in the rear view mirror, what will remain is that people need to be as healthy as possible when calamity comes [5].

***Address for Correspondence:** Yun Zhing, Department of Cardiology, Taizhou Hospital Affiliated to Wenzhou Medical University, Linhai, Zhejiang Province, P.R China, E-mail: Yunzhing@gmail.com*

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Conclusion

Due to its apparent simplicity, logical applicability, and common sense interventions, the medical art of preventive cardiology has failed to receive adequate recognition as a devoted field of cardiovascular medicine. Similar to other medical subspecialties before it, preventive cardiology must strategically plan for a non-disruptive separation from the current main outlets of its components of care (cardiology, endocrinology, lipid clinics, etc.) and plan to connect with all other services used by the patient in need of CVD prevention (diabetes, hypertension, interventional, EP, etc.). This has been carried out thus far using disparate and non-uniform methods. The centre that specialises in preventive cardiology should provide the necessary training and certification for every individual provider who wants to have the entire range of preventive cardiology competencies in the future.

Acknowledgement

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Conflict of Interest

None.

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