key points

SELECTED BY

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Cardiac rehabilitation is a combination of medical and behavioural interventions designed to facilitate recovery and prevent future cardiovascular disease (CVD) events. An effective cardiovascular prevention and rehabilitation programme (CPRP) can be defined as: The delivery of a coordinated sum of activities which favourably influences the underlying cause(s) of CVD, as well as the provision of optimum physical, mental and social conditions to enable patients to take control of their condition, restore function and adopt healthy lifestyle behaviours.

A CPRP is a critical element within the management pathway for most patients with heart disease and has a particularly strong evidence base for those with either symptomatic atherothrombotic vascular disease or heart failure. Following acute myocardial infarction (MI) and/or coronary revascularisation, attending and completing a CPRP is associated with an absolute risk reduction in cardiovascular mortality from 10.4% to 7.6%, when compared with not undergoing a CPRP, with a number needed to treat (NNT) of 37. In addition, there is a significant reduction in acute hospital admissions (from 30.7% to 26.1%, NNT 22). Cardiac rehabilitation does not reduce total mortality in heart failure but does result in a 25% relative risk reduction in overall hospital admissions and a 39% reduction (NNT 18) in acute heart failure related episodes.

Most CPRP sessions occur either within hospital or community-based facilities and are delivered within groups or individually depending on the nature of the intervention. Home-based sessions are becoming increasingly common. Once the programme has been completed, patients must be offered appropriate strategies to maintain long-term healthy behaviours. These may include further semi-supervised and subsidised sessions at local leisure centres, activities organised by the voluntary sector and local authority funded services.

Despite the persuasive evidence base and the overwhelming cost-efficacy profile, only a minority (38%) of eligible IHD patients access and complete a CPRP and most patients with a heart failure diagnosis are not even referred. The pathway to prevention should start from the moment an IHD patient enters the hospital, either as an emergency or for a planned procedure. All cardiology staff should be aware of the critical messages to convey when it comes to the key aspects of CVD prevention and should highlight the merits of cardiac rehabilitation.

GPs are ideally placed to explain the benefits of attending and completing a CPRP to their patients. They can play a key role as community-based champions for CR and provide encouragement, referral details and re-referral opportunities for all eligible patients. GPs should always ask patients with a new diagnosis of either HF or IHD if they have attended, or been contacted by, a CPRP. GPs should be familiar with referral and eligibility criteria for their local CPRP and have direct access to the referral pathway.