Exercise Prescription in Cardiac Patients

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Physical inactivity is an independent risk factor for coronary heart disease. The optimal amount of physical activity is controversial and is an area of challenge. Physical activity also has an impact on secondary prevention. Two meta analyses on RCTs (O'Connor et al, Berlin et al) showed a 20% to 25% reduction in mortality of post MI survivors with regular physical activities. And a more recent study (Jollife, 2001) showed a 31% reduction in mortality with regular physical activity.

Also Weight surveillance is very important. Those with BMI of 20-25 Kg/m^2 are at lower risk for coronary heart disease than those who are overweight or obese (Arch Internal Medicine 2000). The reduction in weight generally is achieved via decreasing energy intake and increasing physical activities (Douketis et al 1999). The primary goal is a 10% weight reduction.

The exercise prescription can be divided in two sets of programs, that is in patient and out patient programs.

The exercise prescription depends on when or whether a cardiac event has occurred before and also depends on the exercise capacity of the patient and should be individualized. A sub-maximal exercise stress test my help exercise capacity out patiently. Exercise tolerance test can help classifying the individuals into categories for special needs on medical supervisions or ECG monitoring during exercise. Also, the contraindications and special precautions have to be addressed in some conditions. Some situations such as silent angina, congestive heart failure, pacemakers and implantable cardiac defibrillators, cardiac transplant are aspects of cardiac patients that need special attention.

For each stage of prescription the FITT (Frequency, Intensity, Time, and Type) should be identified.

These special programming will be reviewed in the presentation.

Appropriate equipment, staffing and safety measures help minimize the rehabilitation programs.

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