THE REHABILITATION OF PATIENTS WITH CORONARY HEART DISEASE

Risteard Mulcahy and Noel Hickey
From the Coronary Heart Disease Research Unit, St. Vincent's Hospital, Dublin 2, Ireland

One-hundred-and-eighty-three male patients with first myocardial infarction were studied from 1961 to 1968 inclusive. All were seen within 1 week of the onset of symptoms and 118 (65%) were admitted on the day of the attack.

Length of total disability was noted, with details of number returning to work or to alternative employment. Reasons for delay or failure to return to work were also noted. The long-term mortality of the patients was studied.

Seventy-five percent of the patients had returned to work within 14 weeks of the start of the illness. One-hundred-and-seventy-one patients (93%) had returned to work by the end of the period of observation. Only 2 patients changed their jobs.

Thirty-three patients who eventually returned to work were disabled for more than 100 days, and 12 failed to return to work. Delay or failure to return was generally related to social or psychological causes. Social reasons included patients who were on full pay during their period of illness, and those who were discouraged from returning by their relatives. Personality inadequacy and chronic anxiety were also important factors. Only 9 of the 32 who had delayed return to work and only 3 of the 12 who failed to return to work were considered to have organic reasons for their prolonged disability.

The long-term mortality of these patients was just over 3% per year on follow-up. This experience compares favourably with reports from other centres in the world.

Acute coronary heart disease depends on the following factors:

1. Knowledge of the good long-term prognosis of myocardial infarction once the initial high risk phase of the illness has been passed.
2. Rapid ambulation after the initial high risk phase of the illness; active physiotherapy while in hospital and thorough investigation to identify and eliminate all risk factors in these patients.
3. The desirability of an early return to the patient's previous employment. Change of occupation is seldom indicated and termination of employment is not desirable in the great majority of patients under 60 years.
4. An acceptance of the fact that early discharge from hospital and early return to previous employment is not associated with increased mortality in these patients.

Successful rehabilitation of patients with coronary heart disease will be achieved if the process of rehabilitation is commenced from the beginning of the patient's illness and if the physicians' approach is a rational optimistic one. The patient's cooperation must be sought in identifying and eliminating all risk factors. With an adequate secondary prevention programme, an early return to normal life, with full physical and psychological rehabilitation, is greatly facilitated.

The return to work experience and the long-term mortality reported by the authors are significantly better than the experience of authors elsewhere.

Address for reprints: R. Mulcahy, M.D., Coronary Heart Disease Research Unit, St. Vincent's Hospital, Dublin 2, Ireland

SEXUAL ACTIVITY AND THE POST CORONARY PATIENT

H. K. Hellerstein and E. H. Friedman

A study was made of the sexual activity (S.A.) of 91 middle-aged, middle-class men (48 ASHD, 43 Normal Coronary Prose—NCP) of comparable background, age and low physical fitness. A subsample of 14 ASHD men was monitored by ECGs during work and S.A. S.A. decreased with age comparably in ASHD and NCP. In 58% of ASHD, it decreased further after the myocardial infarct.

The average number of orgasms/Wk decreased in the ASHD from 4-4 at the age of 25 to 2-1 one year prior to and 1-6 several months after the attack. The decrement in S.A. from the age of 25 yrs to one year prior to the coronary event was more marked in subjects with higher blood pressure, lower income, lessened outwardly directed activity and greater passive dependency at the time of intake into the physical conditioning program, usually more than 6 months after the coronary event. S.A. was resumed on an average of 13-7 Wks after the coronary event, occurring earlier in previously sexually more active subjects.

Abstract of paper read at the Council in Rehabilitation of the International Society of Cardiology. This paper is published in Arch. Int. Med. 135:947, 1970.

The cardiovascular costs of conjugal S.A. were relatively low, compared to many other longer lasting daily living and ordinary work activities. The mean maximal heart rate (MHR) during S.A. corresponding to orgasm and ejaculation, was 117, range 90 to 144. The heart rate of the period encompassing the MHR (2 mins.) averaged 98. The O2 uptake equivalent to the MHR and to the averaged H.R. were 16 and 12 ml O2/kg/B.W./Min., and corresponded to 66 and 45% of the maximal O2 uptake respectively. Changes in the EKG (ST-T depression and/or ectopic beats) during coitus and during regular occupational work were comparable in frequency (28%) and severity. The mean MHR during work was 120, range 107 to 130.

S.A. was influenced favourably by enhancement of fitness by systematic physical training in ASHD and NCP.

In view of the brevity of the duration, the low frequency, the modest HR and equivalent O2 cost, and the symbolic importance of conjugal sexual intercourse, most middle-aged men with ASHD, not in congestive heart failure, can resume this important activity.

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