#### Critical femoral site bleeding or hematoma

#### Femostop

\*\*Follow Femostop orders, package insert & policy\*\* Be sure patient has voided & continues to void; bladder scan!!! Belt position is very important. It should be level with the access

- Hip position is also important-should be level/even
- Femostop should be level with the hips Use caution when removing Femostop- support the artery & skin
- Package insert has great step-by-step pictures to guide you!!
- Retroperitoneal Bleeding or Hematoma

Severe or prolonged bleeding via the acvers or prolonged bleeding via the cavity site collecting in the peritoneal cavity site collecting in the peritoneal cavity site death for femoral access Every femoral access pt is at risk Beginning signs are subtle. They may appear as a vagal response. By the time BP & HR decrease, a significant amount of blood has already significant amount of blood has already Assess for & derr MD with: Assess for & derr MD with: discomfort in scrolalribal area severe lower abdominal pain, fullness or guarding new lower abdominal pain, fullness or guarding femoral neuropathy

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## Cardiac rehabilitation policy and procedure manual



Experimental and Investigational These programs are considered educational and training in nature. Education and training programs are generally not covered under most Aetna benefit plans. Please check benefit plan descriptions. See CPB 0267 Intensive Cardiac Rehabilitation Programs. Cardiac rehabilitation CR serves this purpose by providing a supervised program in the outpatient setting that involves medical evaluation, an ECGmonitored physical exercise program, cardiac risk factor modification, education, and counseling. This includes individuals who have had heart attacks, open heart surgery, stable angina, vascular disease or other cardiac related health problems. Phase I cardiac rehabilitation begins in the hospital inpatient after experiencing a heart attack or other major heart event. During this phase, individuals receive education and nutritional counseling to prepare them for discharge. Phase II outpatient cardiac rehabilitation begins after leaving the hospital. As described by the U.S. Public Health Service, it is a comprehensive, longterm program including medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Phase II refers to medically supervised programs that typically begin one to three weeks after discharge and provide appropriate electrocardiographic ECG monitoring. Phase III and phase IV cardiac rehabilitation programs encourage exercise and healthy lifestyle performed at an outpatient medical facility, home or in a fitness center with the goal of continuing the risk factor modification and exercise program learned in phase II. Phase III and IV do not require direct physician supervision or continuous ECG monitoring. These programs encourage a commitment to regular exercise and healthy habits for risk factor modification to establish lifelong cardiovascular fitness. Some programs combine phases III and IV CMS,

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Although the physician does not have to be present in the room during the CR sessions, all CR settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. Irrespective of the program, there should be regular communication, in the form of progress reports, between the program staff and the patient's attending physician Ignaszewski and Lear, 1998. The exercise test in cardiac rehabilitation is a vital component of the overall rehabilitative process as it provides continuous followup in a noninvasive manner and adds information to the overall physical evaluation. In general, testing is performed before entering the cardiac rehabilitation exercise program, and sequentially during the program to provide information on the changes in cardiac status, prognosis, functional capacity, and evidence of training effect. The central component of cardiac rehabilitation is a prescribed regimen of physical exercises intended to improve functional work capacity and to increase the patients confidence and wellbeing. Depending on the degree of debilitation, cardiac patients may or may not require a full or supervised rehabilitation program. The efficacy of modification of risk factors in reducing the progression of coronary artery disease and future morbidity and mortality has been established. Metaanalysis of data from random controlled studies indicates a 20 % to 25 % reduction in mortality in patients participating in cardiac rehabilitation following myocardial infarction as compared to controls. There are alternative approaches to this typical model. Patients can be classified as low, moderate or highrisk for participating in exercise based on a combination of clinical and functional data.http://dycelife.com/userfiles/e75-service-manual-download.xml

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- emostop- support the artery &
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- Severe or prolonged bleeding via the access site & collecting in the peritoneal This is the leading cause of preventable death for femoral access Every femoral access phils at risk Beginning signs are subtle. They may appear as a vagal response. By the time BP & HR decrease, a significant amount of blood has already been lost.

Retroperitoneal Bleeding or

- lower back pain or discomfort
- discomfort in scrotal/labial area severe lower abdominal pain, fullness or guarding
- guarding new lower abdominal pain, fullness or guarding femoral neuropathy

Hammill et al 2010 stated that for patients with coronary heart disease, exercisebased cardiac rehabilitation improves survival rate and has beneficial effects on risk factors for coronary artery disease. However, the relationship between the number of sessions attended and longterm outcomes is unknown. In a national 5 % sample of Medicare beneficiaries, these investigators identified 30,161 elderly patients who attended at least 1 cardiac rehabilitation session between January 1, 2000, and December 31, 2005. They used a Cox proportional hazards model to estimate the relationship between the number of sessions attended and death and myocardial infarction MI at 4 years. The cumulative number of sessions was a timedependent covariate. The authors concluded that among Medicare beneficiaries, a strong doseresponse relationship existed between the number of cardiac rehabilitation sessions and longterm outcomes. Attending all 36 sessions reimbursed by Medicare was associated with lower risks of death and MI at 4 years compared with attending fewer sessions. Current median time from hospital discharge to enrollment is 35 days. These researchers hypothesized that an appointment within 10 days would improve attendance at CR orientation. At hospital discharge, 148 patients with a nonsurgical gualifying diagnosis for CR were randomized to receive a CR orientation appointment either within 10 days early or at 35 days standard. The primary endpoint was attendance at CR orientation. Secondary outcome measures were attendance at greater than or equal to 1 exercise session, the total number of exercise sessions attended, completion of CR, and change in exercise training workload while in CR. Safety analysis demonstrated no difference between groups in CRrelated adverse events. The authors concluded that early appointments for CR significantly improved attendance at orientation. This simple technique could potentially increase initial CR participation nationwide.

The sample comprised 544 men and women eligible for CR following MI, coronary artery bypass surgery or percutaneous interventions. Participants were tracked 4 months after hospital discharge to ascertain CR attendance status. Main outcome measure was allcause mortality at 14 years ascertained through linkage to the Australian National Death Index. In total, 281 52 % men and women attended at least 1 CR session. There were few significant differences between nonattenders and attenders. While a doseresponse relationship may exist between the number of sessions attended and longterm mortality, this relationship does not occur independently of smoking differences. They stated that CR practitioners should encourage smokers to attend CR and provide support for smoking cessation. CMS allows for physicians to determine the time period over with CR services are provided as long as it falls within the covered time period identified in the CMS regulation. The regulation allows for coverage of up to 36 1hour sessions over up to 36 weeks. Stable patients are defined as patients who have not had recent less than or equal to 6 weeks or planned less than or equal to 6 months major cardiovascular hospitalizations or procedures. Per CMS, CR sessions are limted to a maximum of two 1 hour session per day for up to 36 sessions over a period of 36 weeks. Furthermore, and additional 36 sessions may be warranted and approved by the Medicare contractor under section 1862a1A of the Social Security Act CMS, 2014. It has also been shown that exercise intolerance is associated with a reduced stroke volume SV in POTS, and that the high heart rate observed at rest and during exercise in these patients is due to this low SV. These researchers tested the hypotheses that Cardiovascular responses during maximal exercise testing were assessed in the upright position before and after training. Resting left ventricular diastolic function was evaluated by Doppler echocardiography.



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Results were compared with those of 10 wellmatched healthy sedentary controls. A lower SV resulted in a higher heart rate in POTS at any given oxygen uptake VO2 during exercise while the cardiac output QcVO2 relationship was normal.Furthermore, an UpToDate review on "Postural tachycardia syndrome" Freeman and Kaufman, 2014 does not mention cardiac rehabilitation as a management tool. Smoking cessation and participation in CR are effective in reducing morbidity and mortality. However, these 2 behaviors may interact; those who smoke may be less likely to access or complete CR. These researchers explored the association between smoking status and CR referral, attendance, and adherence. They carried out a systematic literature search examining associations between smoking status and CR referral, attendance and completion in peerreviewed studies published through July 1, 2014. For inclusion, studies had to report data on outpatient CR referral, attendance or completion rates and smoking status had to be considered as a variable associated with these outcomes. A total of 56 studies met inclusion criteria. A history of smoking was associated with an increased likelihood of referral to CR. However, smoking status also predicted not attending CR and was a strong predictor of CR dropout. The authors concluded that continued smoking after a cardiac event predicts lack of attendance in, and completion of CR. The issue of smoking following a coronary event deserves renewed attention. Medline, Embase, the Cochrane Central Register of Controlled Trials CENTRAL in the Cochrane Library and the Chinese BioMedical Literature Database CBM, were searched to April 2014, without language restriction. Existing randomized controlled trials RCTs, reviews, relevant conference lists and gray literature were checked. Randomized controlled trials that compared telehealth intervention delivered CR with traditional

centerbased supervised CR in adults with coronary artery disease CAD were included.

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Two reviewers selected studies and extracted data independently. Main clinical outcomes including clinical events, modifiable risk factors or other endpoints were measured. A total of 15 articles reporting 9 trials were reviewed, most of which recruited patients with MI or revascularization. The authors concluded that telehealth interventiondelivered CR does not have significantly inferior outcomes compared to centerbased supervised program in lowtomoderate risk CAD patients. Telehealth intervention offers an alternative deliver model of CR for individuals less able to access centerbased CR. Choices should reflect preferences, anticipation, risk profile, funding, and accessibility to health service. To update searches from the previous Cochrane review, these investigators searched the Cochrane Central Register of Controlled Trials CENTRAL, The Cochrane Library, Issue 9, 2014, MEDLINE Ovid, 1946 to Week 1 of October, 2014, EMBASE Ovid, 1980 to Week 41 of 2014, PsycINFO Ovid, to Week 2 of October, 2014, and CINAHL EBSCO, to October 2014. They checked reference lists of included trials and recent systematic reviews. No language restrictions were applied. The authors concluded that this updated review supports the conclusions of the previous version of this review that home and centerbased forms of CR seem to be equally effective for improving the clinical and healthrelated guality of life outcomes in low risk patients after MI or revascularization, or with heart failure HF. This finding, together with the absence of evidence of important differences in healthcare costs between the 2 approaches, supports the continued expansion of evidencebased, homebased CR programs. The choice of participating in a more traditional and supervised centerbased program or a homebased program should reflect the preference of the individual patient.

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They stated that further data are needed to determine whether the effects of home and centerbased CR reported in these shortterm trials can be confirmed in the longer term. A number of studies failed to give sufficient detail to assess their risk of bias. These investigators evaluated the effect of CR on total mortality and other clinical endpoints after an acute coronary event. Randomized controlled trials, retrospective controlled cohort studies rCCSs and prospective controlled cohort studies pCCSs evaluating patients after acute coronary syndrome ACS, coronary artery bypass grafting CABG or mixed populations with CAD were included, provided the index event was in 1995 or later. These investigators noted that CR participation was also associated with reduced mortality after CABG rCCS HR 0.62, 95 % CI 0.54 to 0.70 and in mixed CAD populations. The authors concluded that CR participation after ACS and CABG was associated with reduced mortality even in the modern era of CAD treatment. However, the heterogeneity of study designs and CR programs highlighted the need for defining internationally accepted standards in CR delivery and scientific evaluation. These investigators searched the following electronic databases; CENTRAL and the Database of Abstracts of Reviews of Effectiveness DARE in the Cochrane Library, Medline Ovid, Embase Ovid, PsycINFO Ovid, Web of Science Core Collection Thomson Reuters, CINAHL EBSCO, LILACS Bireme, and 3 clinical trial registers on July 14, 2016. They also checked the bibliographies of relevant systematic reviews identified by the searches. They imposed no language restrictions. These researchers included RCTs that examined exercisebased interventions compared with any type of noexercise control. They included trials with adults aged 18 years or older with AF, or posttreatment for AF. Two authors independently extracted data.

They assessed the risk of bias using the domains outlined in the Cochrane Handbook for Systematic Reviews of Interventions. They assessed clinical and statistical heterogeneity by visual inspection of the forest plots, and by using standard Chi.They assessed the risk of random errors with trial sequential analysis TSA and used the GRADE methodology to rate the quality of evidence, reporting it in the "Summary of findings" table. A total of 6 RCTs with 421 patients with various types of AF were included in this review. All trials were conducted between 2006 and 2016, and had short followup 8 weeks to 6 months. Risks of bias ranged from high risk to low risk. The exercisebased CR programs in 4 trials consisted of both aerobic exercise and resistance training, in 1 trial consisted of Qigong slow and graceful movements, and in another trial, consisted of inspiratory muscle training.

The authors concluded that due to few randomized patients and outcomes, they could not evaluate the real impact of exercisebased CR on mortality or serious AEs. The evidence showed no clinically relevant effect on healthrelated QOL. Pooled data showed a positive effect on the surrogate outcome of physical exercise capacity, but due to the low number of patients and the moderate to very lowquality of the underpinning evidence, the authors could not be certain of the magnitude of the effect. Moreover, they stated that future highquality randomized trials are needed to evaluate the benefits and harms of exercisebased CR for adults with AF on patientrelevant outcomes. Cardiopulmonary exercise testing CPET, hemodynamics, and quality of life QOL were assessed before and after CR. No significant betweengroup differences were found for any baseline characteristics.Thus, they could not exclude the possibility that selection bias affected the present results.

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However, no significant betweengroup differences were found in any baseline characteristics, which might strengthen the value of the present results, These results should be confirmed in a large, randomized, multicenter study, The authors could explain this discrepancy by their preliminary data that physicalrelated QOL scores in their patients had already improved to a certain degree before CR via BPA alone data not shown, as well as hemodynamics and functional capacity. Thus, current recommendations are based on patients with ischemic heart disease. In a randomized clinical trial, these researchers examined the effects of CR versus usual care after heart valve surgery. The trial was an investigatorinitiated, randomized superiority trial The CopenHeartVR trial, VR; valve replacement or repair. They randomized 147 patients after heart valve surgery 11 to 12weeks of CR consisting of physical exercise and monthly psychoeducational consultations intervention versus usual care without structured physical exercise or psychoeducational consultations control. Primary outcome was physical capacity measured by VO2 peak and secondary outcome was selfreported mental health measured by Short Form36. Moreover, they stated that further research is needed to justify CR in this patient group. Furthermore, an UpToDate review on "Surgical and percutaneous closure of atrial septal defects in adults" Connolly, 2017 does not mention CR as a management tool. Surgical spetal myectomy relieves LVOT obstruction by directly removing the thickened septal wall. The surgical septal myectomy involves performing a thoractomy, with individual being placed on cardiopulmonary bypass. Surgical septal myectomy results in resolution of the LVOT gradient and improvmeent in heart failure symptoms in most individuals. Longterm outcomes also includes reductions in implantable cardioverterdefibrillator ICD discharges and improvment in left atrial volumes and pulmonary hypertension Maron, 2019.

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In this study, a total of 29 patients were evaluated during graded treadmill exercise before and after operation. Even today, it remains difficult to diagnose it at an early stage, to select a sufficient antibiotic therapy and to choose the right time for surgical intervention. These investigators reported on the case of a 37year old man who presented with anemia, fever, adynamia and a loud systolic murmur over the base of the heart. Blood culture data were positive for Streptococcus mitis. Transthoracic echocardiography TTE revealed an endocarditis of the aortic and mitral valve with regurgitations as well as a hypertrophic obstructive cardiomyopathy. The hemodynamically stable patient was treated with penicillin G, gentamicin and verapamil. Because of an extension of valve vegetations and a decline in the hemodynamic situation with an incipient sepsis, the patient was surgically treated urgently by replacement of the aortic and mitral valve as well as a Morrow septal myectomy. A postoperative sepsis required the application of high catecholamine doses. Because of a respiratory insufficiency, a prolonged mechanical ventilation was required. Finally, the patient could be discharged for inhospital rehabilitation. The authors concluded that the indication for

surgical therapy in patients with endocarditis of the aortic and mitral valve as well as hypertrophic obstructive cardiomyopathy should be critically discussed with regard to the patients age, the aims of conservative therapy, and the consequences of a surgical intervention. If there were any indices of a disease progress in spite of antibiotic therapy, patients should be subjected to cardiac surgery immediately. These researchers hypothesized that guided exercise in a CR program following autologous HSCT is a safe and feasible intervention. This was a pilot project to assess for safety, feasibility and impact of 8 weeks of CR in HSCT patients following transplant.

Consecutive patients with lymphoma underwent standard activity protocol testing before HSCT, at 6 weeks following HSCT prior to CR, and at 14 weeks following HSCT at completion of CR, consisting of grip strength GS, gait speed GtS, timed upandgo TUG, and 6minute walk test 6MWT; CR consisted of 8 weekly visits for guided exercise. Statistically significant improvements were found in GS p Treatment is empiric, and 30 % of patients remain symptomatic in spite of therapy. It is well known that physical exercise can improve endothelial function. These investigators evaluated the evidence on effects of physical exercise in NOCAD patients with angina. They performed a literature search up to March 13, 2018 using the following search terms syndrome X, microvascular angina, nonobstructive coronary artery disease and exercise training, cardiac rehabilitation, endothelial function. All original publications which examined the effect of a CR program or exercise training ET on patients with angina and NOCAD. A total of 8 studies, of which 4 were RCTs, examined 218 participants, 162 in an intervention and 56 in control groups. Most patients were women 97.7 %. Exercise programs varied from 8 weeks to 4 months at moderate intensity and some included relaxation therapy. The studies examined the effect of CR on exercise capacity, QOL, and perfusion defects. CR increased exercise capacity, oxygen uptake, symptom severity, and QOL; myocardial perfusion improved. The authors concluded that CR appeared to be beneficial in symptomatic patients with NOCAD, improving exercise capacity and OOL and reducing severity of symptoms and myocardial perfusion defects. Moreover, these researchers stated that data were limited to a small number of predominantly female patients. They stated that further larger trials with inclusion of men are needed to determine the optimal rehabilitation protocols and define its longterm benefits.

First, the included studies were all small with low patient numbers in each treatment group, thus limiting statistical power. In addition, not all of the studies were randomized. Second, the majority of studies included only women 97.7 %. Although cardiac syndrome X is more common in women, it is well established that it also occurs in men, with up to 30 % of men with SA presenting for coronary angiogram, have NOCAD. Given that the studies were limited to women, these investigators could only speculate whether ET has the same positive effect in men. Outcome measures in the reported trials consisted mostly of parameters for exercise capacity, easily measurable physical values, and QOL assessed by questionnaires. All outcomes were evaluated in the shortterm, directly after completion of the CR program. No data were available on the longterm effects of CR programs in NOCAD, and whether the beneficial effect was sustained over time. Furthermore, it would be interesting to find out whether this transferred into hard endpoints like less frequent hospitalization, lower treatment costs, and possibly an improved outcome. For a long time, symptomatic patients with NOCAD were assured of the benign nature of their condition. However, recent data pointed towards an adverse outcome of these patients in regard to MI, cardiovascular, and allcause mortality. Thus, it would be intriguing to examine if CR also led to an improved cardiovascular outcome in this patient population. These researchers stated that current studies on the effect of ET in symptomatic patients with NOCAD are promising but larger, randomized studies with inclusion of men are needed to evaluate the benefit of ET on hard endpoints and the longterm effect of ET. Furthermore, a study protocol should include randomized groups to determine the optimal training protocol in regard to training intensity, duration, and inclusion of relaxation techniques.

Furthermore, it would be of interest to include vascular function studies to gain further insight into

the pathophysiological mechanisms. According to AACVPR, "monitoring BG levels is vital for the longterm maintenance of glycemic control and is especially important during exercise given that betablocker therapy can mask the onset of an impending insulin reaction. Monitoring BG levels during exercise may also provide positive feedback regarding the regulation or progression of the exercise prescription, which may result in subsequent longterm adherence to exercise. This is particularly important since exercise is a cornerstone of treatment for diabetes" Human Kinetics, 2019. The authors state that it is not necessary to defer exercise based on milder hyperglycemia, as long as the patient feels well and there is no ketonemia or ketonuria. It should be noted that patients can be at risk of late hypoglycemia i.e., 48 hours after the termination of exercise; however, this can usually be avoid by ingesting slowly absorbed carbohydrates immediately after exercise. "Inadequate replacement of carbohydrate before, during, and after exercise is the most common cause of exerciseassociated hypoglycemia in patients taking insulin." The authors note that CR participation has been lower in patients with DM, suggesting the need to identify and correct the barriers to CR participation for this higherrisk group of patients. The endpoints of their study were to evaluate the impact of CR on cardiovascular events and mortality after PCI in patients with DM, and to compare the relative impact of CR on these outcomes in patients with and without DM.Rehabilitation care comprised in addition to remedial exercise a therapeutic regime, clinical and laboratory examinations, diet therapy, medicamentous and physical therapy and carbon dioxide CO2 baths. After rehabilitation care objective improvement was recorded in 850 42.59 %, subjective improvement in 953 47.74 %, no change in 143 7.

16 %, deterioration in 47 2.35 %, and 3 patients 0.15 % died. Clinically, the patient showed leftsided pleural effusion, jugular venous distension, and a congested liver. Under conservative medical treatment, the patient again developed cardiac decompensation and, thus, a pericardectomy was performed. Immediately after surgery, symptoms diminished and exercise tolerance increased. The patient was currently in CR. The authors concluded that constrictive pericarditis is a rare differential diagnosis of right heart failure. Especially in patients with congested inferior vena cava, but normal systolic left ventricular function and normal function of the cardiac valves, constrictive pericarditis should be considered as a differential diagnosis. These researchers presented a clinical case of CP in a patient with rare inherited bleeding disorder factor VII deficiency. Heart failure due to CP was suspected based on clinical symptoms, results of ultrasonic and radiological investigations. The diagnosis was verified by the results of cardiac MRI. Pericardectomy was performed resulting in significant improvement in the patients condition. Cardiac rehabilitation was not mentioned and was not listed as one of the keywords for this study. Consecutive consenting subjects having sustained a transient ischemic attack or mild, nondisabling stroke within the previous 12 months mean of 11.5 weeks; eventtoCCR entry with greater than or equal to 1 vascular risk factor, were recruited from a stroke prevention clinic providing usual care. These researchers measured 6month CCR outcomes following a prospective cohort design. Of 110 subjects recruited from January 2005 to April 2006, 100 subjects mean age of 64.9 years; 46 women entered and 80 subjects completed CCR.

A total of 5 electronic databases were searched from inception to May 1, 2019, namely Medline, PsycINFO, the Cumulative Index to Nursing and Allied Health Literature, the Cochrane Central Register of Controlled Trials, and the Web of Science. Eligible studies included both randomized and nonrandomized studies of CRtype interventions that measured cognitive function in patients with transient ischemic attack TIA or stroke. Of 14,153 records reviewed, 9 studies that delivered CRtype interventions to stroke patients were finally included. Only 3 of these studies delivered cognitive rehabilitation as part of the intervention. These investigators noted that the CR model has the potential to be expanded to include patients poststroke given the commonality of secondary prevention needs, thereby becoming a cardiovascular rehabilitation model. Up to 50 % of patients experience cognitive impairment following stroke; suggesting that a poststroke cardiovascular rehabilitation model should incorporate specific cognitive strategies for patients. This systematic review identified 3 cardiovascular rehabilitation programs which delivered cognitive rehabilitation as part of treatment; however, evidence for efficacy was weak. For physiological assessment, fractional flow reserve FFR during dobutamine challenge was measured in 37 consecutive adult patients with lone right ACAOS with interarterial course. In spite of the potential mortality benefits of receiving an ICD device, psychological problems experienced by patients after receiving an ICD may negatively impact their healthrelated QOL, and lead to increased readmission to hospital and healthcare needs, loss of productivity and employment earnings, and increased morbidity and mortality. Evidence from other heart conditions suggested that CR should consist of both exercise training and psychoeducational interventions; such rehabilitation may benefit patients with an ICD.

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