

LETTER TO THE EDITOR

Can We Reduce the Socioeconomic Burden of Acute Myocardial Infarction Already in the Acute Phase?

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In patients with acute myocardial infarction (AMI) who survive the acute coronary event, the acute phase represents only the first part of a long-term journey. Work reinsertion after AMI remains a significant part of a successful recovery, a process in which a complete social reintegration involves a complex interplay between clinical, psychological, socio-demographic, and occupational factors.

With 40% of AMI survivors at working age according to WHO reports, and an increasing value in the next decades due to the aging process of the working population, employment in the post-infarction period can generate significant socioeconomic outcomes.¹ Based on experts' agreement, the main factors related to return to work were the patients' rehabilitation, age, educational status, social support, and job satisfaction.

Despite the recent advancement of acute management in AMI patients which led to an increasing number of patients returning to work after an acute coronary syndrome, approximately 15% of AMI patients at working age do not return to work within 1 year, this owing to the fact that AMI patients present at least one comorbidity burden.¹ Moreover, the percentage of AMI patients who returned to their previous jobs remains almost similar to the one recorded in the last century, ranging between 15–25%.²

From an economic point of view, AMI involves a substantial socioeconomic burden. In order to establish the cost-of-illness related to AMI, it is mandatory to consider both direct and indirect costs. Direct healthcare costs are those related to treatment and caregivers, while the

indirect costs are those related to loss of productivity at the workplace and at home, which could also have damaging consequences. Indirect costs include those related to morbidity (the days of work lost due to AMI and home productivity loss) and those resulting from mortality (the value of lost earnings and household productivity from premature death due to AMI). With individuals aged between 45–64 facing the highest indirect costs, it has been estimated that in the European Union, 90 million working days are lost a year due to AMI morbidity, being the leading cause of disability-adjusted life-years.^{2,3}

In order to improve the social reinsertion of AMI patients, the current trend of cardiovascular rehabilitation is to include a comprehensive therapeutic approach. Besides standard implemented invasive therapy followed by medical treatment and out-of-hospital cardiac rehabilitation, recent studies showed that early rehabilitation nursing by early mobilization, functional exercise guidance, diet care, pain and mental nursing, initiated after 24 h of stable vital parameters, can significantly improve the prognosis of AMI patients, resume work ability, and reduce the family and society burden.³ Moreover, occupational therapy associated with disease self-management, via counselling and therapeutic education interventions, can significantly reduce the risk of sub-optimal patient recovery.⁴

It is obvious that AMI has several consequences in terms of functional restrictions and limitations of occupational participation, which are frequently neglected in scientific literature. In my opinion, such complex consequences of this serious illness should be better

underlined and reflected in the published AMI-related research, as work reintegration of these patients represents a major socioeconomic challenge. Furthermore, the proper initiation of supportive measures targeting social reinsertion already in the acute phase of AMI, an often neglected intervention in acute cardiovascular care units, can significantly improve the prognosis of these patients and reduce the socioeconomic burden of this devastating disease.

CONFLICT OF INTEREST

Nothing to disclose.

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