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EVALUATION OF THE LEVEL OF KINESIOPHOBIA IN PATIENTS WITH HEART FAILURE

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In recent years, secondary prevention programs focused on physical activity and cardiac rehabilitation and have been widely used as prevention of all causes of cardiovascular mortality and morbidity. However, insufficient participation and adherence to rehabilitation programs are an increasing problem for the population due to limited daily life activities. Meanwhile, patients with chronic diseases or avoidance behavior in pain characterize an adaptive part of the behavior as a natural response to damage and only part of them will suffer true kinesiophobia without being able to avoid their fear. Kinesiophobia is a fear of physical exercises that might get worse in case of cardiovascular disease.

The aim of the study was an assessment of the level of kinesiophobia for cardiac function evaluated by clinical parameters in patients with cardiovascular disease. The analysis of clinical, laboratory, instrumental, including echocardiographic (Echocardiography) in 81 patients (28 women) aged 61.9 ± 7.48 years hospitalized in the acute coronary insufficiency unit was performed. Kinesiophobia was assessed using the Tampa Scale of Kinesiophobia Heart (TSK-Heart) questionnaire. The Finnish version of the TSK (14) (TSK-FIN) was used to assess the fear of movement/(re-)injury. The TSK-FIN is a 17-item questionnaire. Each item is assessed using a 4-point Likert scale: strongly disagree, disagree, agree, or strongly agree. A total score is calculated after first inverting items 4, 8, 12, and 16. The scores range from 17 to 68; a higher score indicates a greater fear of movement. TSK value greater than 37 was a cut-off point for high kinesiophobia.

In case of concomitant valve pathology (valves insufficiency), a significantly higher TSK compared to the mean or mild (45.7 ± 2.05 vs. 37.9 ± 3.18, $p <0.05$) was observed. TSK scores increased with age ($p <0.05$), higher in women than in men (45.71 ± 3.14 vs. 38.11 ± 2.19, $p = 0.05$) and in patients with atrial fibrillation (45.3 ± 3.23 vs. 35.9 ± 3.38, $p <0.05$). There was a significant inverse association between kinesiophobia and leisure-time physical activity in both sexes after adjusting for age. Index TSX rises significantly in the case of severe heart failure (NYHA IV) than in the lower classes ($p <0.05$). Patients with heart failure are characterized by increasing body mass index ($p = 0.05$).

Thus, among patients with cardiovascular disease, kinesiophobia has many causes and increases with the progression of the symptoms of heart failure. We have presented reference values for the TSK-FIN. Age and the TSK-FIN score were associated with one another in both sexes; older age groups had higher scores than younger ones. Men had higher mean scores overall and there were also gender differences in an item-by-item comparison.

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CLINICAL AND INSTRUMENTAL MARKERS OF ACUTE MYOCARDIAL INFARCTION COMPLICATED BY ACUTE HEART FAILURE FLOW EVALUATION

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Determination of prognosis within first year after acute myocardial infarction (AMI) remains one of the most topical issues of cardiology.

368 patients were examined with the purpose to create a prognostic model of acute myocardial infarction complicated by acute heart failure course. Some risk factors of lethal outcome were distinguished.

Transmural AMI occurred in 141 (38.32%), macrofocal AMI – in 166 (45.11%) and microfocal AMI – in 61 (16,57%) cases as established by results of complex clinical-instrumental examination including detailed complains collection, anamnesis, careful clinical investigation, electrocardiography in dynamics. 123 (33,42%) persons out of 368 examined died throughout