Health Promotion to Reduce Delays in Seeking Medical Attention in Patients With Acute Coronary Syndrome

Promoción de salud para reducir el retraso en buscar atención médica de los pacientes con síndrome coronario agudo

To the Editor,

The well-known adage, "time is money", rephrased as "time is muscle", becomes "time is life" when we interpret the findings of Rivero et al.[1]

The greatest benefit from myocardial reperfusion is obtained 120 to 180 minutes after the onset of ischemic symptoms.[2] A reduction in the delay in seeking medical attention (DSMA) would make it possible to reach the most appropriate therapeutic time window for reperfusion of the culprit artery and to salvage a greater portion of myocardium at risk, which would almost certainly save many lives.[3]

The authors mention a few limitations[1]; however, their report sheds sufficient light on the subject to enable the identification of a highly important aspect on which it is possible to act. Similar investigations in other Spanish communities would reveal the magnitude of the problem in this country.

Aside from the socioeconomic variables and those involving the people living with the patient,[1] other patient-dependent factors that could influence DSMA are the level of culture, rural living, personal autonomy, and degree of disability. However, health promotion, at all possible levels and ages, is the only intervention that adequately trains the population[4] to recognize ischemic symptoms and, thus, reduce DSMA.

The statement that this time period "depends exclusively on the patient"[1] could generate controversy, because the failure to react rapidly to the symptoms is entirely up to the individual, but the time "may depend on us", on health promotion and education,[5] on what we are capable of conveying to the population.

We were right to reduce the time between the first medical contact and the passage of the guidewire into the coronary artery,[1–3] but we have not done enough to reduce the DSMA, which independently affects mortality[1] and quality of life.

In Spain, prevention strategies are very effectively employed,[4,6] but primary prevention is still insufficient. Health education is fundamental and is not the responsibility of medical professionals, the Spanish Heart Foundation, and other public or private institutions alone; it is also a concern of the Spanish state and government, which should allocate funds to involve the media in order to reach even those sectors of the population with low educational levels. The purpose now is not only to stimulate healthy lifestyles and control atherogenic risk factors, among other approaches[4,6]; Rivero et al have demonstrated the need to reduce the DSMA in the center of Madrid, the Spanish capital. Strategies based on new information and communication technologies, such as ehealth,[7] big data,[8] and crowdfunding,[9] are useful in this respect.

An old aphorism states that the mission of the physician is "to cure sometimes, to relieve often, to comfort always", but prevention is better.[4–7] If the population can be taught to seek medical attention as soon as the symptoms of myocardial ischemia are suspected, it will be possible to "cure"—understood to mean "treat"—more often and, consequently, more lives will be saved and the quality of other lives will improve. Nevertheless, the strategies proposed by health administrators should take into account the impact of these interventions on health costs, as they mean more emergency department visits and the resulting increase in the use of diagnostic techniques; but it is a price is worth paying, for the good of the patient.

Francisco L. Moreno-Martínez,[a,*] Elibet Chávez-González,[b] María T. Moreno-Valdés,[c] and Ricardo Oroz Moreno[d]

[a]*Unidad de Hemodinámica y Cardiología Intervencionista, Cardiocentro Ernesto Che Guevara, Villa Clara, Cuba*
[b]*Departamento de Electrofisiología y Arritmias, Cardiocentro Ernesto Che Guevara, Villa Clara, Cuba*
[c]*División Estrategias de Innovación, Tecnalia, Bilbao, Spain*
[d]*Facultad de Medicina, Universidad de Navarra, Pamplona, Navarra, Spain*

[*] Corresponding author:
E-mail address: flmorenom@yahoo.com (F.L. Moreno-Martínez).

Available online 24 May 2016

REFERENCES

1. Rivero F, Bastante T, Cuesta J, Benedicto A, Salamanca J, Restrepo JA, et al. Factores asociados al retraso en la demanda de atención médica en pacientes con síndrome coronario agudo con elevación del segmento ST. Rev Esp Cardiol. 2016;69:279–85.
2. Windecker S, Kolh P, Alfonso F, Collet JP, Cremer J, Falk V, et al. Guía de práctica clínica de la ESC sobre revascularización miocárdica, 2014. Rev Esp Cardiol. 2015;68. 144.e1-e95.
3. Rodríguez-Leor O, Fernández-Nofrerías E, Mauri F, Salvatella N, Carrillo X, Curós A, et al. Análisis de los tiempos de atención en pacientes con infarto agudo de miocardio tratados con angioplastia primaria según su procedencia y según el horario de realización del procedimiento. Rev Esp Cardiol. 2011;64:476–83.
4. Castellano JM, Peñalvo JL, Bansilal S, Fuster V. Promoción de la salud cardiovascular en tres etapas de la vida: nunca es demasiado pronto, nunca demasiado tarde. Rev Esp Cardiol. 2014;67:731–7.
5. Shah A, Clayman ML, Glass S, Kandula NR. Protect your heart: a culture-specific multimedia cardiovascular health education program. J Health Commun. 2015;20:424–30.
6. Mazón-Ramos P. Riesgo cardiovascular en el siglo xxi. Cómo detectarlo en prevención primaria. Cómo controlarlo en prevención secundaria. Rev Esp Cardiol. 2012;65 Supl 2:3–9.
7. Ordúñez P, Tajer C. Disseminating cardiovascular disease risk assessment with a PAHO mobile app: a public eHealth intervention. Rev Panam Salud Publica. 2015;38:82–5.
8. Joynt KE, Mega JL, O'Donoghue ML. Difference or disparity: will big data improve our understanding of sex and cardiovascular disease? Circ Cardiovasc Qual Outcomes. 2015;8:S52–5.
9. Fumagalli DC, Gouw AM. Crowdfunding for personalized medicine research. Yale J Biol Med. 2015;88:413–4.

SEE RELATED ARTICLES:
http://dx.doi.org/10.1016/j.rec.2015.07.029
http://dx.doi.org/10.1016/j.rec.2016.04.012

http://dx.doi.org/10.1016/j.rec.2016.03.016