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ORIGINAL ARTICLE

(RE) DEFINING HEALTH CARE: THE ACCOUNT OF PEOPLE COMMITTED BY ACUTE MYOCARDIAL INFARCTION

(RE) SIGNIFICANDO O CUIDADO À SAÚDE: O RELATO DE PESSOAS ACOMETIDAS PELO INFARTO AGUDO DO MIOCÁRDIO

(RE) SIGNIFICANDO EL CUIDADO A LA SALUD: EL RELATO DE PERSONAS ACOMETIDAS POR EL INFARTO AGUDO DEL MIOCARDIO

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ABSTRACT

Objective*:** dismiss the definition of acute myocardial infarction from the lives of people stricken by the disease. ***Method*:** this is a study of a qualitative nature, in the light of the symbolic interactionism. The accounts of the interviewed parties were analyzed and divided into two thematic categories. Twenty-four victims of acute myocardial infarction were interviewed at a ischemic heart disease clinic in a public hospital, and of reference in cardiology, in Bahia. ***Results*:** Under the category "life before the infarction" the interviewees revealed, in their majority, that they are not concerned in seeing a doctor and had inadequate living habits because they did not feel ant symptoms, and in the category "life after infarction", began having restrictions in the pleasures of life, as well as negative implications in their lives. ***Final considerations: the study reveals the necessity of implementing measures for promoting cardiovascular health care from childhood, contemplating people in various socio-economic levels, emphasizing the importance of adapting the language in order for the awareness of these people. ***Descriptors*:** infarction; daily life; nursing.

RESUMO

Objetivo*:** destacar o significado do infarto agudo do miocárdio para a vida das pessoas acometidas pela doença. ***Método: estudo de natureza qualitativa, a luz do Interacionismo simbólico, com 24 pessoas vítimas de infarto agudo do miocárdio que frequentaram o ambulatório de cardiopatia isquêmica de um hospital público e de referência em cardiologia na Bahia – Brasil, no período de 15 de dezembro de 2010 a 15 de janeiro de 2011. Foi elaborado um roteiro semi-estruturado para a realização das entrevistas gravadas e as falas foram analisadas e apresentadas em categorias temáticas. O projeto foi apreciado pelo Comitê de Ética e pesquisa do Hospital Ana Nery, parecer número 063/2010. ***Resultados***: na categoria "a vida antes do infarto" os entrevistados revelaram, na sua grande maioria, que não se preocupavam em procurar o médico e tinham hábitos de vida inadequados porque nada sentiam e na categoria "a vida após o infarto" passaram a ter restrição aos prazeres da vida, além de implicações negativas na sua vida em sociedade. ***Considerações finais*:** o estudo revelou a necessidade de implementação de medidas de promoção à saúde cardiovascular desde a infância, contemplando as pessoas de variados níveis socioeconômicos, ressaltando a importância da adequação da linguagem para o alcance do entendimento dessas pessoas. ***Descritores*:** infarto; cotidiano; enfermagem.

RESUMEN

Objetivo*:** destacar el significado del infarto agudo del miocardio para la vida de las personas acometidas por la enfermedad. ***Método: se trata de un estudio de naturaleza cualitativa, a la luz del interactionismo simbólico. Los relatos de los entrevistados fueron analizados y divididos en categorías temáticas. Fueron entrevistadas 24 personas víctimas de infarto agudo del miocardio que frecuentaron el ambulatorio de cardiopatía isquémica de un hospital público y de referencia en cardiología en Bahia. ***Resultados*:** en la categoría "la vida antes del infarto" los entrevistados revelaran, en su gran mayoría, que no se preocupaban en procurar el médico y tenían hábitos de vida inadecuados porque nada sentían y en la categoría "la vida después del infarto" pasaran a tener restricciones a los placeres de la vida, aparte de implicaciones negativas en sus vidas en la sociedad. ***Consideraciones finales*:** El estudio revela la necesidad de implementación de medidas de promoción a la salud cardiovascular desde la infancia, contemplando las personas de variados niveles socio-económicos, resaltando la importancia de la adecuación del lenguaje para el alcance del entendimiento de las personas. ***Descriptores*:** infarto; cotidiano; enfermería.

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INTRODUCTION

Cardiovascular diseases (CVD) consist in a group of causes with high rate of morbidity and mortality all around the world. At least half of deaths occur within 1 hour after the onset of symptoms and before the patient gets to the hospital's emergency room.[1] In 2004, 7.2 million people died due to coronary arterial disease (CAD), representing 12.2% of total deaths in the world, something which leads it to the first position in the "top ten leading causes of death" from the World Health Organization (WHO). In developed countries, this disease is ranked in first position and in developing countries it is ranked in second position among registered deaths.[2] One estimates that there will be 8,501,299 deaths by 2015 and 9,843,472 deaths by 2030 due to ischemic heart diseases.[3]

CVDs are the main causes of mortality in the Brazilian population. The main causes of death, among men, are the ischemic heart diseases and the cerebrovascular diseases, as among women the cerebrovascular diseases prevail. The atherosclerosis process and its complications are the main reasons for morbidity and mortality in CVDs, stimulated and strengthened by the traditional risk factors: age, gender, smoking, dyslipidemia, diabetes mellitus, and systemic arterial hypertension. Other genetic and environmental factors are also involved in variable degrees of importance with regard to the etiology of these pathologies.[4]

In Brazil, as in the world, the acute myocardial infarction (AMI) has a relevant impact in terms of mortality and the number of hospitalizations. Considering the statistics, costs are related to AMI incidence and prevalence.[5] These information demonstrate the need for more comprehensive studies, which shall guide the prevention and rehabilitation standards for the individuals who have this pathology, besides orientating a health policy towards CVDs.

Following the world tendency, an increased mortality due to cardiovascular events between 1997 and 2007 also occurred in Brazil. In 1997 248,273 deaths were registered and in 2007 they totaled 308,095. In accordance with its group of causes, deaths due to AMI also had an increase in the said period, with 56,128 registered deaths in 1997 and 71,902 in 2007. Still preliminary data showed that in 2008 74,538 deaths due to AMI occurred in the country.[6] The panorama on morbidity and mortality caused by the cardiovascular system pathologies has become an object for attention and investigation because of the impact of these harms on the subject's life, her/his family, the society, and the State.

AMI prevention is a key point, and changes in lifestyle are crucial for a good prognosis for the disease. Sedentary lifestyle, poor feeding practices, inadequate life habits, daily life stress, and exposition to risk factors are aggravating aspects shared by many people. Despite a lot of campaigns encouraging healthy life habits, there still exists an avoidance to adopt activities which guarantee a good quality of life and prevent the emergence of biological complications leading to CVDs and, as a consequence, AMI. Many times, a change in such habits develops in an impelled manner, after the exposition to a beginning heart attack or to AMI itself, being, thus, a survival issue.

Lifestyle before the heart attack determines the risk level for triggering the said ischemic cardiopathy and the biopsychosocial impact on the individual after the event. At the same time, this lifestyle involving a prevalence of risk factors for the cardiovascular system, such as smoking, alcoholism, inadequate dietetic habits, and sedentary lifestyle, before AMI and during the period of heart rehabilitation, can or present some changes or not in the period after AMI.[7]

The nursing care to the person suffering from AMI should be driven towards treatment, limitation/control of damages, as well as health prevention and promotion activities, in order to decrease the morbidity and mortality due to the disease. Thus, the health education process is essential to the caring process, for preventing the emergence and progression of cardiovascular disease and contributing to control it.[8]

Within this context, it's necessary to understand that relations among sickening, life history, the subjects' way of life, and the care procedures they perform.[9] This understanding can be the first step for, as a whole, drawing individualized prevention strategies. If the individuals know the underlying reasons for her/his choices and are able to include the need for change as a way of preserving her/his own life, it's possible that they change their daily behaviors before a heart attack occurs, or even that these people who experienced a heart attack stop concentrating on the losses caused by the disease.

From this starting point, under the light of Symbolic Interactionism, the following question emerged: "How do the victims of

acute myocardial infarction face their lives before and after the event?".

THEORETICAL FRAME

Symbolic Interactionism represents one of the main schools of thought in sociology and it has the characteristic of incorporating reflexivity in the analysis on action.[10] The foundations of Symbolic Interactionism lie on three assumptions: the human being acts regarding things with the meanings they have to her/him as a basis; the meaning of things derives or originates from the social interaction that the individual establishes with the others; these meanings are handled and modified through an interpretive process used by the person to deal with things and situations she/he finds her/himself in.[11]

Social interaction is symbolic when it involves an interpretation of the act, a reflective process. Meanings assume a great relevance, because actions are only responsive without them, senseless. Thus, people's gestures take part in the social interaction and contribute to the understanding of it.

A person not only determines her/his objectives, but applies her/his own perspectives for defining the situation. She/he realizes herself/himself, therefore, as member of a group, with a place in society. Once the situation is defined, she/he is able to guide her/his own behavior according to a set of meanings established by the group. Under the light of Symbolic Interactionism, it's possible to apprehend the meanings of heart attack for those who experienced an event of this disease.

In AMI, an area of the heart muscle is permanently destroyed, generally because of decrease blood flow in a coronary artery, due to disruption of an atherosclerotic plaque and the subsequent artery occlusion by thrombus. The other causes of myocardial infarction include the vasospasms of a coronary artery, decrease oxygen supply, and increased demand of oxygen by the heart muscle.[12]

The typical presentation of myocardial infarction is characterized by a pressing left-sided precordial pain, radiating to left upper limb, with high intensity and prolonged duration (> 20 minutes), which does not resolve or it only has a partial relieve with rest and sublingual nitrates. Radiation through the mandibular, upper right limb, back, shoulders, and epigastrium is also possible. In diabetic patients, elderly people, or in the post-operative period a heart attack can occur with no pain, but with nauseas, illness, dyspnea, tachycardia, or even mental confusion.[13]

Therefore, one realizes the importance of preventing the progression of coronary disease and the harmful factors to health which can lead to an AMI. For this, the individuals should adopt healthy lifestyles which minimize the emergence of risk factors associated to the disease.

These risk factors may be classified as changeable and unchangeable. The latter ones include advanced age, gender, race, and family history of atherosclerotic disease and coronary cardiopathy.[14] A changeable risk factor is the one over which a person can take control, e.g., modify a lifestyle, a personal habit, or use a medicine. An unchangeable risk factor is a circumstance over which a person does not have control, e.g., heredity. A risk factor can act in an independent way or along with other risk factors. The more risk factors a person has, the higher the likelihood of coronary artery disease.[12]

The changeable factors, that is, those over which the patient and even the health care staff can take control, are dyslipidemias, systemic arterial hypertension (SAH), smoking, diabetes mellitus (DM), sedentary lifestyle, nutrition, stress, and obesity. Other factors which can also be associated to the development of AMI are excessive intake of alcoholic beverages, menopause, use of oral contraceptives, hyperuricemia, increased fibrinogen levels, and others, which, however, require more studies for clarification.[4]

There are "behaviors which characterize people who are likely to have a heart disease: competitiveness, rush sensation or impatience, aggressiveness, and hostility" .[12] There are socioeconomic circumstances that can lead the individual to a feeling of stress, rage, depression and/or anxiety. It's known that these emotion patterns have a physiological dimension which is predictive of AMI.[15]

The prevention of AMI is related to the identification and control of risk factors which are present in the lifestyle of the individuals. Its high incidence in Brazil is, in part, related to the fact that we find in our population a lifestyle which favors the development of the risk factors, which, without any doubt, contribute to an increase in the number of individuals with this disease.[16]

METHOD

This is a qualitative study within the theoretical perspective of Symbolic Interactionism. The research subjects were

AMI victims who underwent hospitalization, adult people aged 18 years or over who presented cognitive ability to answer to the study questions, after agreeing to participate in the study through the signing of the Free and Informed Consent Term (FICT).

The research was carried out in the outpatient department of a public hospital which is a reference center in cardiology in the State of Bahia, Brazil, divided into specialties. In average, about 150 patients are treated per day, who are distributed according to the specialty concerned from Monday to Friday, 7 a.m. to 5 p.m.

The medical team consisted of many professionals and students in residency training, each one practicing her/his specialty. The physician could treat up to 32 patients a day, 50% in the morning shift and the remaining ones in an afternoon shift.

The nursing team consisted of 2 nurses, 3 nursing technicians, and 2 nursing assistants. Besides these professionals, the team had the contribution of 2 receptionists and a minor apprentice, who helped perform administrative tasks. Before medical consultation, the individuals underwent a triage and, soon afterwards, stood in the waiting room. At this moment, we could ask for the participation of respondents whose diagnosis were confirmed through the medical records and, once agreed, they were conducted to a reserved room, where the interviews were held.

The data were collected within the period from December 15, 2010 to January 15, 2011, in the ischemic cardiopathy outpatient department of a public hospital which is a reference center in cardiology in the State of Bahia, Brazil. A script was developed in order to carry out a semi-structured interview, aiming to obtain information with regard to the subjects' sociodemographic characterization and also to issues that involve the meaning of the disease in their lives. The interview was recorded with the consent of the respondent, so that she/he did not feel tired and to allow a higher dynamism, avoid time loss and, especially, guarantee reliability of information, and anonymity.

The data from closed questions, the clientele characterization, were analyzed having absolute numbers and percentage values as a basis.

For analyzing the data from open questions, one of the techniques of Bardin's Content Analysis was used; this model is defined as:

> *A set of techniques for communication analysis aiming to obtain, through systematic and objective procedures for the description of the messages' content, indicators which allow the interference of knowledge regarding conditions of production/reception of these messages.*[17:42]

The technique adopted was Thematic Analysis, aiming to understand the manifest and latent meanings in the collected material. The analysis steps were preanalysis, fluctuating reading, material exploration, categorization, and data interpretation.

All ethical issues concerning researches involving human beings were observed, as well as the bioethical principles (autonomy, no maleficence, beneficence, and justice). Therefore, we observed the dispositions of Resolution 196, signed on October 10, 1996, from the Brazilian National Health Council, which regulates the researches involving human beings. The project was submitted to the Research Ethics Committee of Hospital Ana Nery, under the Opinion 063/2010.

RESULTS AND DISCUSSION

Twenty four heart attack victims were interviewed, who underwent hospitalization due to AMI and attended the ischemic cardiopathy outpatient department of a hospital which is a reference center in cardiology in the State of Bahia, within the period from December 15, 2010 to January 15, 2011. After the invitation to participate in the research, in a voluntary manner, people were conducted to one of the rooms of the outpatient department and the interviews were conducted individually. After the reading and explanation of the Free and Informed Consent Term, which was signed to two sheets, one of which remains with the researchers, who shall keep it in a safe place during five years.

Regarding gender, 54% of respondents were women and 46% men. 36% were aged from 60 to 70 years. With regard to skin color, 71% stated to be mulatto, 21% black, and 8% white. Concerning working conditions, 48% were retired people. It is worth stressing that 84% lived in a house of their own and 33% lived with just 1 minimum wage. With regard to education level, 52% had incomplete primary school education.

Out of the female respondents, 21% stated to be black, 50% mulatto, and 14% white, as 15% said to be "brown-skinned", similar to the mulatto ones. Concerning education level, 14% of respondents were illiterate, 81% had

incomplete primary school education, and 14% had complete primary school education. Out of the male respondents, 17% stated to be black and 83% stated to be mulatto. It's relevant to highlight that there data were collected in a Brazilian state that is historically known for the predominance of black-skinned people in its population, something which justifies the percentage values found. With regard to education level, 50% had complete primary school education, 42% had incomplete primary school education, and 8% had higher education.

Analyzing the data on the occupation of respondents, it was found that most of them (48%) were retired people, who were distributed this way: 16% female and 32% male. Among the other occupations, 24% were housemaids and the remaining 28% were distributed among the jobs of caretaker, security agent, fisher, microentrepreneur, seamstress, farmer, and furniture maker.

Regarding the analysis on the economic level through family income, it was found that 58% of respondents presented an income lower than two minimum wages. It worth establishing the relation between the number of wages and the number of dependants, since there is a tendency that the lower the family income, the higher the number of dependants, something which is realized in the analysis on the data of this research. This low income may justify the reports of difficulty for purchasing medicines and healthy food, evidenced through the following speech:

> A24: *Life habits are better, but I can't support them. Because there's a need for fruit, linseed, integral products, but I can't purchase them, and also all medicines I take, which are many, it's very difficult.*

In this study, age ranged from 43 to 74 years, with a mean age of 59 years. It was verified a 36% predominance of the age group ranging from 60 to 69 years. With regard to marriage status, the married ones prevailed in this sample, with 15 individuals (60%), followed by the widowers, 4 (16%), singles, 4 (16%), and those divorced, 2 (8%).

Table 1. Life habits of people who experienced a heart attack (before the event)

Habit	n	%
Poor feeding practices	12	33
Smoking	5	14
Alcoholism	4	11
Physical and/or emotional stress	11	31
Sedentary lifestyle or lack of physical exercise	4	11
Total	36	100

One sees a dispersed distribution of answers in this category, evidencing that the individuals under analysis expressed themselves in a heterogeneous manner, describing varied life habits experienced in daily life before AMI which are considered potential risk factors for the development of this disease.

Individual decisions can affect health status. And life habits which are considered inadequate cause risks for the individual her/himself, once they favor the emergence of risk factors which play a role in the development of AMI.[16]

The results displayed in Table 1 show that poor feeding practices is the most prevalent risk factor among the individuals under study, it reveals to be the main life habit before individuals suffer a heart attack. The subsequently ranked ones are physical and emotional stress, smoking, alcoholism, and sedentary lifestyle and/or lack of physical exercise, respectively are related to many adverse effects which can lead to cardiovascular diseases and, as a consequence, an AMI. Besides, the practice of physical exercises involves protection, prevention, and control mechanisms with regard to the remaining risk factors referred to, something which suggests that the lack of these exercises can contribute to the contrary effect, favoring the development of AMI.

One notices that respondents presented a higher number of answers revealing a prevalence of poor feeding practices (33%) and physical and/or emotional stress (31%). The latter datum reveals that physical effort, especially in job tasks, and concerns due to varied personal situations can, somehow, strengthen the mechanisms of cardiovascular risk factors and influence physiological changes favoring AMI.

The testimonies pointed out many dimensions for the development of the event, as we can see below:

> A16: *I got annoyed about anything, complained. I stress myself.*
>
> A18: *I got angry, my blood boiled and I had a thrombosis that caused a heart attack.*
>
> A2: *I smoked a lot, my main problem was the cigarette addiction.*
>
> A10: *I worked a lot, I didn't sleep at night.*

A5: *Sedentary lifestyle. I drunk, smoked, ate things I shouldn't, often I didn't sleep through the night.*

A7: *I ate much fried food, much meat, calabrese sausage, I only ate fried and fat food, I was grown eating fat food in the countryside, fat cow milk, dende palm oil, every bad food product, there was a lot of annoyance, family problems, trouble with regard to other things, a lot of annoyance.*

The dialogues show that people are aware of their poor feeding practices, as we can see in the expression underlined above, however, something which surpasses understanding may also justify such an attitude, as the rush of modern life, that is realized through the faster rhythm of daily life, which leads many people to have their meals in fast-food restaurants, forgetting the healthy 15 minutes of rest after lunch, to underwent hours of stress in very heavy traffic, in short, the technological inclusion provided many benefits, but it brought up some harms to the health of human beings.

Although it has not been displayed in Table 1, it was possible to realize in the speech of respondents that some individuals have already been diagnosed with arterial hypertension and most part of the post-heart attack changes was due to restrictions in the levels of dietary sodium.

The observations show that the development of the disease is related to the increase in the pressure levels. At the same time, epidemiological studies have revealed an association between the low level of physical exercise and the presence of arterial hypertension, according to researches indicating that regular physical exercise reduces the pressure levels.[4]

Table 2. Life habits of people who experienced a heart attack (after the event)

Habit	n	%
No change in lifestyle	1	2
Change in feeding practices	11	21
Alcoholism and smoking cessation	3	6
Aggregation of diseases	5	9
Search for medical consultation	2	4
Change in leisure activities	7	13
Introduction of a pharmacological therapy	7	13
Restriction of physical effort	9	17
Emotional change and/or emotional stress	6	11
Introduction of physical exercise	2	4
Total	53	100

The data displayed in Table 2 reveal, especially, a change in the lifestyle, evidenced through restrictions that respondents faced after a heart attack. Among the main life habits that changed after the event we highlight feeding habits (21%) and the limitations to physical effort. These data reveal the impact level of AMI with regard to the performance of daily life activities, suggesting that these people experienced a "disruption of daily life".

The association between life habits and feeding was very clear, indicating that inference with pleasures provided by tasting affects the psychological structure, with a posterior biological repercussion, revealing, this way, the importance of maintaining a healthy feeding behavior.

The inability to carry out in a spontaneous manner her/his duties and leisure activities, as well as the restriction to physical effort demonstrates the limitations posed by the ischemic event. These conditions reveal a loss of the vigor and power needed to determine spontaneity in daily life, the individuals have to "adapt" their activities to those established within the feasible possibilities, according to the following testimonies:

A4: *Some things become restricted, restricted with regard to health itself, some things I can't do anymore, as lifting a weight.*

A5: *Everything changes, I can't undergo physical effort, I can't practice a sport, play soccer, nothing.*

A19: *I stopped doing many things I did before, play soccer, lift weight...*

A6: *I can't go out often, I have to sleep early, because if I go to bed late I'm gonna pay the consequences.*

A18: *I have no amusement, I don't play soccer anymore.*

A study revealed that the sudden way in which myocardial ischemia occurs lead to the development of an emotional instability, coming from a harsh stop on habits and common patterns or emotional stress, disturbances, and anxiety, and this emotional change or stress is highlighted by a significant 11% value.[18] Limitations pose conflicts that interfere with the social relations, which was evidenced in some dialogues:

A20: *It always lead to a sequel in our mind, because you know that you had a heart attack, a stop, in fact, you returned from death through a device, it has a strong*

impact on our mind and our emotions, but we have to avoid thinking on it, I'm still trying to absorb it and go on.

A16: *Now, both my children and my husband make everything to prevent me from getting annoyed.*

A2: *Some days I get very nervous.*

A17: *It changed so much that now it's very difficult for me even to start a new relationship.*

A7: *I became depressed after the heart attack, very emotionally sensitive.*

The exacerbation of typical symptoms in the period pre- and post-heart attack, such as difficult breathing, tiredness pain during physical exercise and, lacking resources to solve them, the victims of AMI decide to search for medical care trying to get rid of discomforts, as the data displayed in Table 2 show. Sureness that signs and symptoms were caused by a heart problem with a potential death risk, such as the theme of this paper, lead 6% of the individuals under study to see the introduction of pharmacological therapy as an obligation to observe the schedule for the ingestion of medicines, the main life habit change, as mentioned below:

A1: *I never visited the doctor, especially the cardiologist, only after the heart attack, because I felt nothing.*

A13: *After the heart attack, I take a lot of medicines.*

One realizes some changes in deeply rooted habits after the heart attack, such as smoking and alcoholism, as about 4% of respondents revealed to quit them. The impact is so strong that there is a revelation of many tries to stop smoking and drinking, but only the "shock" of living moments with fear of dying lead to the said factors:

A19: I stopped smoking and drinking, I also don't drink anymore after the heart attack, stop smoking was better, because I couldn't stop anyway, as well as drinking.

A13: I don't smoke, I don't drink.

The many testimonies of daily activities which do not promote a good health status, especially the practice of eating fatty food with a high level of dietary sodium, favor the emergence and aggregation of diseases that persist in the post-heart attack period, as represented in Table 2.

The data from Table 2 reveal that only 4% of the individuals introduced physical exercise in their daily living, considering that this activity should be according to the patterns of her/his functional capacity and that it demands a medical follow-up. In the interviews, it was noticeable that there is a search for the physician in order to introduce physical exercise in the routine of people who suffered a heart attack. According to what was shown, one realizes that the heart attack develops impacts which determine changes in the lifestyle of its victims, however, it was found that only 1 respondent (2%) didn't implement any changes in her/his life habit, avoiding them and disregarding the risks involved.

CONCLUSION

The study revealed important aspects on the health care to the victims of AMI before and after the event. It was realized that most people did not set criteria for a healthy life in the period preceding ischemic disease, on the contrary, it was noticed a euphoria for living life fully and intensely and taste the most exquisite flavors. Concerns with life habits emerge when biofunctional changes which are characteristic of this disease occur and there's a need for medical care. This fact has an impact on the lifestyle of these individuals, requiring reeducation with regard to their customs.

After the heart attack, a huge majority of respondents reported the attribution of a new meaning to her/his life. For this, it was necessary to acquire new life habits, besides living with daily restrictions, both in the organic and personal domains, as well as in the sociocultural and collective ones.

It was also possible, under the light of the Symbolic Interactionism, to understand and interpret the lives of victims of a chronic disease and its repercussions in the social environment.

The study revealed the need for implementing measures for cardiovascular health promotion since childhood, including people from different socioeconomic levels and highlighting the importance of using an adequate language so that people are able to understand these measures. In this sense, nursing plays a leading role in the process of health education, aiming to prevent complications from AMI, of people with this disease, from their hospitalization to their discharge, ambulatory follow-up and attention in the primary sectors of health care services.

In this sense, the nurse's role within this context comprise indispensable aspects for the development of strategies aiming to guarantee adhesion to treatment and correction of risk factors for the disease.[19]

REFERENCES

1. Goldman L, Ausiello DC. Tratado de Medicina Interna. 22. ed. Rio de Janeiro: Elsevier; 2005.

2. World Health Organization. Health situation in the Américas.Basic Indicators. Premature mortality due to cerebrovascular diseases; 2009.

3. World Health Organization. Closing the gap in a generation. Health equity through action on the social determinants of health. Commission on Social Determinants of Health, final report, Geneva: World Health Organization; 2008. 256 p.

4. Sociedade Brasileira de Cardiologia. Diretriz de Reabilitação Cardíaca. Arq Bras Cardiol. 2005; 84(5):431-40.

5. Guimaraes HP, Avezum A, Berwanger O, Piegas L. Epidemiologia do infarto agudo do miocárdio/Epidemiology of acute myocardial infarction. Rev Soc Cardiol Estado de São Paulo, SP. 2006 Jan-Mar;16(1):1-7.

6. Brasil [internet]. Ministério da Saúde. Informações de Saúde. Brasília, Datasus 2010 [updated 2011 Apr 20; cited 2011 Apr 20]. Available from: http://w3.datasus.gov.br/datasus/datasus.php?

7. Berry JR, Cunha AB. Avaliação dos Efeitos da Reabilitação Cardíaca em Pacientes Pós-Infarto do Miocárdio. Rev Bras Cardiol. 2010 Mar/Apr; 23(2):101-10.

8. Sampaio ES, Mussi FC. Cuidado de enfermagem: evitando o retardo pré-hospitalar face ao infarto agudo do miocárdio. Rev Enferm UERJ [Internet]. 2009 July/Sept [cited 2010 Oct 22];17(3):[about 5 p.]. Available from: http://www.facenf.uerj.br/v17n3/v17n3a25.pdf

9. Mussi FC. O infarto e a ruptura com o cotidiano: possível atuação da enfermagem na prevenção. Rev Latino-Am Enfermagem [Internet]. 2004 Oct [cited 2012 Mar 18];12(5):751-59. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692004000500008&lng=en. http://dx.doi.org/10.1590/S0104-11692004000500008.

10. Dupas G, Oliveira IC, Terêsa NA. A importância do interacionismo simbólico na prática de enfermagem. Rev Esc Enf USP. 1997;31(2):219-26.

11. Blumer H. Symbolic interacionism: perpective method. Berkeley, University of California; 1969.

12. Smeltzer SC, Bare BG. Tratado de Enfermagem Médico-Cirúrgica. 11 ed. Rio de Janeiro: Guanabara Koogan; 2009.

13. Pesaro AEP, Serrano JR, Carlos V, Nicolau JC. Infarto Agudo do Miocárdio: síndrome coronariana aguda com supradesnível do segmento ST. Rev Assoc Méd Brasil. 2004 Jan-Apr;50(2):214-20.

14. Cunningham S. The epidemiologic basis of coronary disease prevention. Nurs Clin North Am. 1992: 27(1):153-65.

15. Strike P, Steptoe A. Behavioral and Emotional Triggers of Acute Coronary Syndromes: a sistematic review and Critique. Psichosomatic Medicine. 2005 Mar-Apr; 67(2):179-86.

16. Colombo RCR, Aguillar OM. Estilo de vida e fatores de risco de pacientes com primeiro episódio de infarto agudo do miocárdio. Ver latino-am enfermagem. 1997 Apr;5(2):69-82.

17. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 1979.

18. Santos FLM, Araújo TL. Vivendo infarto: os significados da doença segundo a perspectiva do paciente. Rev Latino-am Enfermagem. 2003;11(6):742-48.

19. Nóbrega ESL, Medeiros ALF, Leite MCA. Atuação do enfermeiro no controle da hipertensão arterial em Unidades de saúde da família. Rev enferm UFPE on line [Internet]. 2010 Jan/Mar [cited 2012 Jan 18];4(1):45-55. Available from: http://www.ufpe.br/revistaenfermagem/index.php/enfermagem/article

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