

BRIEF REPORT

ANXIETY IN HEART FAILURE

Konstantina Tsalamata

MSc in Applied Clinical Nursing, University of West Attica, Department of Nursing, Athens, Greece

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Corresponding author: Tsalamata Konstantina, E-mail: konstantinatsalamata@gmail.com

Heart failure (HF) consists a global health problem. In this clinical syndrome, heart is unable to deliver the cardiac output which is required to meet the body's demand at the prevailing hemodynamic status.¹⁻⁵

According to estimates, HF affects more than 26 million individuals, globally and more than 15 million in Europe^{1,4} as well as more than 10% of individuals above 70 years old.⁴ The disease is expected to expand enormously due to the ageing of population and increased survival after cardiovascular disease.¹ Specifically more, HF is expected to rise by 25% until 2030.⁴

This debilitating disease is associated with increased morbidity and mortality. More in detail, contributes to 5% of all emergency hospital admissions in Europe and USA.⁵ In Greece, annual mortality rates reach approximately 24.3% for hospitalized patients while annual re-hospitalization rates amount to 42.9% for those having a prior hospitalization and 19.2% for outpatients.⁶

Anxiety is a common mood disorder in HF⁴ with approximately 30% of patients to meet clinically significant levels of anxiety.⁷ A recent meta-analysis showed prevalence of 13.1% for anxiety disorders, 28.79% for clinically significant anxiety, and 55.5% for elevated symptoms of anxiety. Rates of anxiety were highest when measured using the Brief Symptom Scale-Anxiety scale.³

Assessing anxiety within the context of HF is a great challenge because both conditions share many common symptoms including fatigue, palpitations, chest pains, breathlessness, and several others.^{1,7,8} Furthermore, anxiety often co-exists with depression and overlaps in symptoms. In patients with major depression, anxiety may reduce antidepressant efficacy and lead to depression persistence.⁶

Anxiety in HF is associated with limited functional ability, frequent exacerbations, increased rates of mortality and poor cardiac outcomes including re-hospitalizations. Possibly, anxiety is associated with adverse outcomes in HF mainly through biological mechanisms (inflammation, autonomic and endothelial dysfunction, platelet aggregability) and behavioral mechanisms (poor medication adherence and non adherence to healthy behaviors :poor diet, smoking, physical inactivity).^{1,5} Anxiety can negatively affect the quality of the breath, creating panic and chest pain, thus exacerbating the symptoms of HF.⁸

Though, anxiety up to some extent is considered a normal response which prompts individuals to seek for early medical help, however high or intense anxiety is associated with a poor prognosis in HF.⁹

In Greece, a relevant study illustrated that among 190 hospitalized HF patients, the 32.6% experienced high levels of anxiety.⁹ Aggelopoulou et al.,¹⁰ showed

high levels of both trait and state anxiety in 231 Greek HF outpatients while factors associated with high levels of anxiety were older age, low level of education, unemployment, poor economic situation, multiple hospitalizations and HF stages III and IV in New York Heart Association (NYHA) Functional Classification.

A recent study in Greece, showed moderate levels of anxiety among 100 HF outpatients, of whom 64% were men and 66% above 70 years old. Additionally, female gender, NYHA IV were associated with anxiety while an one point increase in anxiety implied an increase in QOL score (worsening) by 1.22 points.¹ Regarding gender, Celik et al.,¹¹ who explored 420 HF patients demonstrated that women were more anxious than men. Interestingly, anxiety in female gender is may attributed to behavioral, social, or physiological vulnerability toward anxiety or to the higher frequency in reports.³

Despite, the high prevalence of anxiety in HF, the rates of recognizing and treating anxiety still remain quite low.¹¹ In everyday clinical practice, exploration of

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anxiety is not emphasized, thus placing patients at risk for the consequences of untreated anxiety.¹²

Health professionals may fail to manage anxiety effectively since they consider it as a natural response to the disease, they pay more attention to the treatment of cardiac disease, they do not devote sufficient time to assessing anxiety symptoms or they are not adequately educated to recognize them.¹²

Anxiety should be treated with psychological therapy, pharmacotherapy, or a combination of both¹² while educational interventions scheduled on patients' needs may empower their effort to manage this emotional burden, more efficiently.¹³ Needs orientated approach is related with many benefits such as stress alleviation, effective collaboration with health care professionals, satisfaction of provided care and better compliance to the therapeutic regimen.¹³

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