

Physical retraining in heart failure: evaluation of 30 patients at the Abidjan Institute of Cardiology (Ivory Coast)

ABSTRACT

Background: Evaluation during heart failure (HF) rehabilitation helps identify the risk factors for poor adherence to physical exercise. Nevertheless, contradictions exist and few studies ~~focus~~ focus on the motivation in the pursuit of sports activity.

Material and Methods: That was (?) is a retrospective cohort pilot study of 30 heart failure patients who underwent cardiac rehabilitation between January 2015 and January 2019 at the Abidjan Institute of Cardiology in Ivory Coast. The patients and their treating physicians were recontacted on an average of 19 months after their rehabilitation to specify their therapeutic adherence as well as the short-term and long-term clinical and paraclinical benefits.

Result:

Our study showed that there were clinical and paraclinical advantages in both the short-term and long-term rehabilitation at the Abidjan Institute of Cardiology. However, only 44% of the participants pursued physical exercise after rehabilitation. Lack of endurance at the end of the rehabilitation ($p=0.049$) and the insufficient motivation ($p=0.021$) were related to poor adherence to physical activity.

Conclusion :

The endurance at the end of rehabilitation and patient motivation seem to be related to the continuation of the physical activity. The Observed Progress in Endurance (OPE) is a novel variable which has been proposed to identify the potential least observant or compliants patients (incorrect English).

Key words: Heart failure, rehabilitation, motivation, endurance, long-term adherence

INTRODUCTION

Numerous studies have demonstrated the short and long-term efficacy of rehabilitation in patients with heart failure; nevertheless, the pursuit of exercise is the key for the long-term rehabilitation success in order to maintain the acquired benefits [1-4, 9,14, 15]. The patient's adherence or observance to physical exercise is underdocumented and probably different from that observed in large cohorts of voluntary patients.

Despite the little knowledge on this ~~obersvance~~ observance, the European Society of Cardiology has identified

it as the main obstacle to the wide spreading of physical exercise in heart failure [4]. Remarkably, while only 60% of eligible cardiac patients are referred to the rehabilitation centers [4], adherence to physical exercise appears to be extremely low with 40% [5].

Wittmer et al. [16] have recently observed that the initial evaluation allows the identification of new risk factors for future poor observance. They include low maximal aerobic power, high body mass index (BMI), smoking, isolation and presence of diabetes [16]. All these objective factors of non-compliance or non-observance are found in the study of Marzolini et al [7]. However, there are some contradictions with Sanderson et al. [16] who have revealed that the presence of diabetes favours better compliance [16]. Similarly, Chien et al. [17] have shown that a low BMI is associated with poor compliance [17]. All these studies are of high quality. In contrast, the motivation theme is partially investigated. Tierney et al [18] have confirmed the effectiveness of some motivational methods within heart failure patients for the observance. Is motivation a variable explaining the link between poor observance and these findings, sometimes contradictory?

The European Society of cardiology, as explained in the treatment section, takes a position for both hypotheses [4]. Assuming that motivational factors are significantly culture-dependent, French research study in this field remains relatively underdeveloped. Consequently, the French Society of Cardiology is planning a multicenter study on the Maintenance of Physical Activity after cardiac rehabilitation in France (EMAP study) [19].

The main objective of this study was double. First, the study was directed to determine whether there was a clinical and/or paraclinical benefits in the short term and long-term retraining program in patients with heart failure at the Abidjan Institute of Cardiology. Second, it aimed at determining if physical activity was continued and if not why, in order to describe the population at risk of not following the recommendations, mainly, physical activity for long-term rehabilitation for heart failure.

Material and methods: That was a retrospective cohort pilot study including 30 patients who underwent cardiac rehabilitation between January 2015 and January 2019 at the Abidjan Institute of Cardiology (ICA). Prior to the course of rehabilitation, the patients included in the study had heart failure with LVEF $\leq 45\%$ and completed a 20-day rehabilitation course at the ICA. Non-inclusion criteria were consisted of the presence of respiratory failure and incomplete pre and post-exercise stress test data. That "pilot" study did not require prior calculation of the number of patients needed for the study. The studied variables were consisted of demographic factors (age, sex, socio-professional, and family status), of cardiovascular risk factors, of other significant history, of cardiovascular treatment, of pre and post cardiovascular rehabilitation items, such as the metabolic panel, results of the 6-minute walking test, results of the Hospital Anxiety and Depression Scale (HADS) score [21], performance of the exercise stress test, and results of cardiac ultrasound.

The main categories of factors of poor therapeutic observance and the clinical and paraclinical markers of possible improvement or worsening were evaluated. The questionnaires were derived from the factors of non-observance or non-compliance described by the European Society of Cardiology [4].

Patients were contacted exclusively by telephone at the number listed on their medical file. After oral information, all patients were asked for authorization through the telephone call. Patients who did not respond to the calls were excluded or deceased. A questionnaire was designed for the treating physicians. The following values were compared before and after rehabilitation: BMI, metabolic panel results (total, HDL, and LDL cholesterol, triglycerides, glycemia), 6-minute test results (HR before and immediately after the test, and traveled distance), HADS score (appendix 10), and subscores corresponding to anxiety and depression, LVEF on transthoracic echocardiography, exercise stress performance values: peak ~~of~~ VO2 measured from the Kahlén formula, HR, power, and deadline at ~~the~~ first threshold and maximal effort. Note that we also used in our calculations the endurance, which is the maximum power that can be maintained by a patient during a 30-minutes (?).

Statistical analysis: Given the pilot nature of the study, non-parametric tests were only used in this study. The Wilcoxon test was used for before and after comparisons of continuous variables. The Fisher's exact test for binary variables and the Mann-Whitney test for continuous variables were utilized to separate the variables according to their presumed relationship to physical exercise. The description of the subjective variables was ~~doneby~~ done by giving the absolute number and the proportion of patients regarding each variable.

RESULTS

I. Description of study population

➤ *Population of study*

The study population was consisted of 30 patients selected among 380 people. The mean age was 57 years old and 17% were women (Table 1).

Table 1 : Population of study

Year	Number of stays	Mean age	Women (%)
2018	136	55.70	17.47
2017	78	57.24	20.11
2016	77	58.6	18.20

2015	89	58.8	12.40
Total	380	57.33	16.97

➤ Demographic factors of patients

Patients enrolled in the study were followed according to the pattern described in the Table 7 and the Figure 2.

Table 2: Recruitment of 30 patients

	2019	2018	2017	2016	2015
Number of recruited patients	1	18	2	0	9

The mean deadline to follow-up questionnaire was 18.9 months with a median deadline of 10 months (Figure 1).

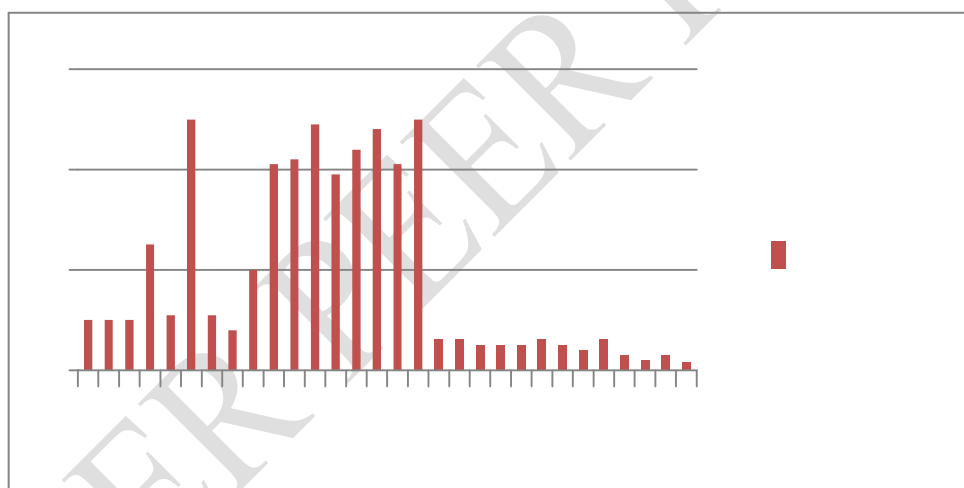


Figure 1 : Post-rehabilitation recruitment deadlines

Table 3: Demographic factors of 30 patients

Criteria	Number (%)*
Mean age at réadaptation	55.63
Proportion of femmes	20 %
Socioprofessionnel category	Public servants
	21 (70)
Family status	Private sector workers
	9 (30)
	Married
	21 (70)
	Single
	9 (30)
	Low house
	24 (80)

Accommodation	Apartment	5 (16.7)
	Family in the village	1 (3.3)
Cardiovascular risk factors	Tobacco/smoking	13 (43.3)
	Obesity	16 (26.7)
	High blood pressure	22 (73.3)
	Diabetes	11 (36.7)
	Sédentarity lifestyle	15 (50)
	Alcohol	4 (13.3)
	Dyslipidemia	24 (80)
	Stress	18 (60)
	Heredity	12 (40)
	History of atrial fibrillation	3 (10)
Revascularisation	Stenting	14 (46.7)
Implantation of a pacemaker	Pacemaker	1 (3.3)
	Ischemic	23 (76.7)
Etiologies	Monotruncular	13 (43.3)
	Bitruncular	6 (20)
	tritruncular	3 (10)
	Missing data	3 (10)
	Dilated cardiomyopathy	5 (16.7)
	Valvular	2 (6.7)
Traitments	Béta-blockers	28 (93.3)
	ACE inhibitors	23 (76.7)
	Diuretics	18 (60)
	ARA-II	6 (20)
	Anticoagulants	4 (13.3)
	Antiplatelet agents	25 (83.3)
	Fibrates	1 (3.3)
	Statin	24 (80)
	Current inhibitor If	3 (10)
	Aldosterone antagonist	16 (26.7)

* With the exception of age and proportion of women

➤ Demographic factors of physicians

All the 28 treating physicians included in the study worked in city. 14% of them were women. They had an average of 6 years of practice (Table 4).

Table 4 : Characteristics of 28 treating physicians

Total number	Number of women (%)	Urban practive site (%)	Years of practice after the thesis (mean)
28	4 (14%)	28 (100%)	6

➤ Participation rate in follow-up questionnaires

✓ *Patients*

Of 30 patients included in the study, 2 died, 1 refused to participate in the study (how was he included in the study then?), and 2 others could not be reached. A total of 25 patients participated into the study.

✓ *Physicians*

Among 28 treating physicians, 5 did not respond (what is the relevance??). Among the respondents, 2 lost the contact with their patients, and 1 had no data on a patient who had died several months earlier. A total of 22 treating physicians participated into the study.

II. Results of the study

➤ Study of medical files

To study the impact of short-term rehabilitation, a before and after study was performed (Table 5).

Table 5: Before and after results of 30 files

		Mean		Wilcoxon's p
		Input	Ouput	
Metabolic parameters	Total cholesterol (g)	1.741	1.545	0.01*
	HDL cholesterol (g)	0.428	0.422	0.82
	LDL cholesterol (g)	1.012	0.854	0.02*
	Triglycerides (g)	1.529	1.37	0.41
	Fasting glycemia (g)	1.172	1.24	1
	BMI (kg/m2)	31.097	30.787	0.016*
6-minute walk test	Distance (meters)	493.167	545.667	0.0001*
	HR - T0 (per min)	73.567	72.467	0.53
	HR- T6 (per min)	96.267	98.967	0.75
Score HADS ???	Anxiety	8.316	5.684	0.001*
	Depression	5.632	4.895	0.26
	Total	13.421	10.684	0.01*
	Endurance (watts)	48.438	52.5	0.19
	Exercice duration (min)	2.433	3.854	0.0001*

1st ventilatory threshold	Power (watts)	52.833	69.7667	0.00002*
	HR (per minute)	97.333	94.767	0.62
	VO2 (ml/kg/min)	10.74	12.877	0.0006*
Maximum capacities	Exercise duration (min)	5.533	7.334	0.00001*
	Power (watts)	84.433	106.433	0.000003*
	HR (per min)	114.9	117.867	0.33
Echography	VO2 (ml/kg/min)	14.902	17.975	0.00006*
	LVEF (%)	33.905	39.429	0.005*

HDL- High Density Lipoprotein, LDL- Low Density Lipoprotein,

BMI-Body Mass Index,

HR- Heart Rate,

Peak of VO2- Oxygen consumption, Kahalin formula,

FEVG- Left Ventricular Ejection Fraction

* Significant difference according to the Wilcoxon test

➤ Study of follow-up questionnaires

The Table 11 described the responses to the patient questionnaires for the binary variables. The same study was done in the Table 13 by treating physicians. The Table 14 described the continuous variables for both populations.

Binary variables of patient questionnaires

Table 6 : Binary variables questionnaire 25 patients

Simplified statements	Number of patients in agreement (%)
Registration to a sports club	3 (15)
Mortality	2 (8)
Rehospitalizations for cardiovascular causes after rehabilitation	7 (28)
Treatment omission	5 (20)
Improvement of quality of life since rehabilitation	21 (84)
Daily physical exercise – essential	17 (68)
Less dyspnea since rehabilitation	18 (72)
Better knowledge of the disease since rehabilitation	23 (92)
Less anxiety and depression since rehabilitation	15 (60)
Stimulating family members to exercise	15 (60)
Good memory of rehabilitation at Abidjan Institute of Cardiology	25 (100)
Lack of resources - cause of inefficient exercise	9 (36)

Good explanation to continue exercises at home or at the ICA	23 (92)
Confidence in treating physician	25 (100)
Treating physician encouraging physical exercise	17 (68)
Good integration of physical exercises in the lifestyle	18 (72)
Side effects of physical exercises other than shortness of breath or fatigue	2 (8)
Motivational problems to do physical exercises	18 (72)
Patients reporting daily 45 minutes or more physical activity	11 (44)

✓ *Binary variables of physician questionnaires*

Table 7 : Binary variables of 22 physician questionnaires

Simplified statements	Number of physicians agreeing or responding positively (%)
Patient observing the treatment	20 (91)
Improvement of life quality after rehabilitation at ICA	22 (100)
Decrease of dyspnea after your patient's rehabilitation	19 (86)
Better patient knowledge of the disease after rehabilitation	16 (73)
Improvement of psychological condition (anxiety/depression) after rehabilitation	15 (68)
Rehabilitation is an essential treatment in HF	22 (100)
Cardiac rehabilitation is an effective treatment	23 (100)
Except obesity, correction of cardiovascular risk factors	13 (59)
Patient counselling in favor of physical exercise	18 (82)

✓ **Continuous variables of both physician and patient questionnaires**

Table 8 : Continuous variables of physician and patient questionnaires

Variables	Mean*
NYHA before rehabilitation according to TP	3
NYHA after rehabilitation according to TP	2
Last LVEF	37.8
Last HDL cholesterol	0.37
Last LDL cholesterol	0.83
Last glycemia level	1.39
Current BMI	32.1
Last systolic blood pressure within TP (mm Hg)	122.5
Last diastolic blood pressure within TP (mm Hg)	70.8
Exercise time including walking reported by patient	0.738

* Except for the NYHA score where the median is used

TP-Treating physician, mm Hg – millimeters of mercury

Comparison of files and follow-up questionnaires

Table 9 : Comparison of patient files

	At the release of mean rehabilitation	Current mean	p-value
NYHA score	3	2	0.0005*
LVEF	39.4	37.8	0.57
HDL cholesterol	0.42	0.37	0.17
LDL cholestérol	0.85	0.83	0.57
Glycemia	1.24	1.39	0.031*

* Statistically significant according to Wilcoxon test; for NYHA, the score was reported during the period before rehabilitation ° Median for NYHA score

Variables related to non-observance

Non-observance or non-compliance is defined as insufficient physical exercise according to the recommendations. In this study, a daily activity of less than 45 minutes was considered insufficient. In the Tables 16-20, a relationship was examined between adequate physical activity and different variables.

From the study of the files

Continuous variables

Table 10: Variables of files related to physical exercise

		Sports		p-value**
Exit variables *		Yes	No	
Metabolic variables	Glycemia	1.65	1.07	0.628
	Total cholesterol	1.62	1.57	0.713
	LDL cholesterol	0.84	0.915	0.792
	HDL cholesterol	0.36	0.46	0.409
	BMI	32.9	29.85	0.261
6-minute Test	Distance at 6 minutes	582.73	550.71	0.762
	HR T0	75.91	68.79	0.124
	HR T6	106.45	94.786	0.162
	Endurance	64.28	43.33	0.049 ^o
HADS score	Anxiety	6.78	4.7	0.303
	Depression	5.67	4.2	0.284
	Total	12.67	8.9	0.129
First threshold	Power	77.55	67	0.459
	HR	94.73	95.93	0.602
	Deadline	3.89	4.1	0.825
	Peak of VO2	13.73	12.96	0.742
Maximum capacity	Power	121.45	98.36	0.17
	HR	122.72	116.64	0.38
	Deadline	7.32	7.59	0.763
	VO2	19.37	17.71	0.805
	LVEF	36.36	36.64	0.92

HR – Heart Rate,

BMI – Body Mass Index,

Mean values at the end of rehabilitation,

According to Mann and Whitney test, ^o Significant test

✓ **Binary variables**

Table 11 : Variables of files related to physical exercise

<u>Statements</u>	<u>Physical exercises</u>		<u>p-value</u>
	<u>Yes</u>	<u>No</u>	
Male	9	1	1
Assisted living	9	1	0.661
Being on leave	9	9	0.407
Living in a house	9	1	0.661
Sinus rhythm	9	1	0.183
Ischemic etiology	8	1	0.623
Diabetes	4	5	1
Hereditiy	4	7	0.689
Sedentary lifestyle	4	9	0.238
High Blood Pressure	8	1	1
Obesity	7	7	0.689
Dyslipidemia	9	1	1
Alcohol	2	2	1
Stress	8	8	0.676
Smoking	3	8	0.227
Pacemaker	2	3	1

* Significant result according to Fisher's exact test

From follow-up questionnaires of patients

Table 12 : Variables of the questionnaires related to physical exercise

Simplified statements	Physical exercises		p-value
	Yes	No	
Improvement of the quality of life	10	11	0.604
Daily physical exercise – essential	9	8	0.233
Less dyspnea	8	10	1
Better knowledge of the disease	10	13	1
Less anxiety and depression	7	8	1
Registration at the Heart and Health Clubs	2	1	0.564
Rehospitalizations	2	5	0.406
Traitements omissions	2	3	0.825
Good memory of rehabilitation	11	14	1
Lack of resources	2	7	0.207
Better explanation to continue the exercises	10	13	1
Confidence in the treating physician	11	14	1
A supportive treating physician	9	8	0.233
Good integration of exercise into lifestyle	9	9	1
Side effects of physical activities	2	0	0.18
Motivational problems	5	13	0.021
Significant result			

➤ *From questionnaires of physicians*

Table 13: Variables of questionnaires related to physical exercise

Simplified statements	Physical exercises		P- value
	Yes	No	
Patient observing the treatment	7	11	0.42
Improvement of life quality after rehabilitation	9	11	1
Decrease of dyspnea after rehabilitation	8	9	1
Better patient knowledge of the disease after rehabilitation	6	9	0.44
Improvement of psychological condition after rehabilitation	6	8	1
Rehabilitation is an essential treatment in HF	9	11	1
Cardiac rehabilitation is an effective treatment	9	11	1
Except obesity, correction of cardiovascular risk factors	4	8	1
Patient counselling in favor of physical exercise	8	9	1
Using Fisher's exact test			

➤ *Continuous variables from questionnaires of patients and physicians*

Table 14: Continuous variables related to physical exercise

Variables (mean)	Sports		p-value
	Yes	No	
Deadline in months	12.86	15.79	0.526
Age at rehabilitation	52.27	56.36	0.546
Age on questionnaire	53.18	57.64	0.458
LVEF*	44.67	33.375	0.22
HDL cholestérol*	0.35	0.38	0.65
LDL cholestérol *	0.88	0.82	0.54
Glycemia*	1.48	1.2	0.94
BMI*	34.33	29.98	0.26
Systolic pression*	124.5	121	0.6
Diastolic pression*	71	71	0.88

* Last known value, ** According to Mann and Whitney test, BMI - Body Mass Index
Pressure in millimeters of mercury

➤ *Open questions*

Patients and physicians were asked about actions to be taken so that patients undergoing cardiac rehabilitation would continue their rehabilitation as recommended. In addition, physicians, who did not advise patients for physical exercise after rehabilitation, were asked about the reasons for this action.

✓ Patient questionnaire

Among 25 patients who answered this question, 6 did not want any change in the system and exercised for more than 45 minutes a day.; 4 patients had no opinion on this question. For the other answers, the semantic analysis and by verbatim highlighted 2 groups of answers. 14 of these responses were about the post-rehabilitation period while 4 responses were about the rehabilitation period.

First, reviewing the lexical items associated with the post-rehabilitation period:

- the first problematic is clearly that of "motivation" (5 citations) and "stimulation" (1 reference);
- this "motivation" seems to be strongly linked to a notion of "follow-up" (2 references and 11 synonyms);
- another promoter of "motivation" seems to be the "group" (4 uses and 4 other synonyms), and is opposed to "isolation" used only once but with a negative connotation;
- other proposals are interested in the "Heart and Health" association (4 citations) and in particular propose to improve its "accessibility" (3 references).
- Only one proposal offers financial assistance.

Second, listing the themes concerning to the rehabilitation period:

- it is mostly about the modalities of the internship. The first modality seems to be the duration of the internship (2 citations), the second being the frequency (1 citation) and the accessibility (1 mention).

✓ Questionnaires of physicians

Out of 22 responses collected, 3 had no opinion on this question. Unlike the patients, the general physician only considered the post-rehabilitation period in the other responses:

- The main theme was undoubtedly "motivation" and cited 6 times as well as its synonyms mentioned 4 times;
- Similarly to the patient questionnaire, for the treating physicians, this "motivation" is linked to "follow-up" (5 references) and to the "rehabilitation center" (2 citations)
- Some responses provide specific indications:
 - encouragement of enjoyable activities,
 - limitation of television watching,
 - limitation of car travel,
 - Reduction of fees of clubs and training of specialized "coaches"

Regarding to the non-support for physical exercise, 4 (18%) physicians did not advise patients for physical exercise. The reasons were mentioned in cases as followed:

- ✓ 1 active patient active (he is working);
- ✓ 2 patients were unable to exercise because of their clinical conditions, such severe dyspnea and disabling back pain.

Discussion

1. Main results, comparison with the literature

➤ **Short-term results of rehabilitation in heart failure**

The recruitment of women was 20% in this study, which is comparable to the 28% found in the HF-ACTION Study (133). The COACH study showed a higher percentage of women with 38% (261). Despite some variability in proportions, women appear to be less represented than men in the rehabilitated heart failure population [144,262, 263].

The pre and post-rehabilitation study showed several significant improvements in all categories of variables.

First, metabolic status improved with decreases in LDL cholesterol, total

cholesterol ($p=0.02$; $p=0.01$, respectively) and BMI ($p=0.016$).

These changes appeared to be more due to the rehabilitation program than to drug management [264,265].

Similarly, walking distance was significantly increased ($p=0.0001$).

Exercise test values: exercise duration, power, and VO_2 were increased at first and maximum threshold ($p<0.001$). These results are comparable to those of large cohort studies [6].

Thereafter, LVEF was also significantly improved ($p=0.005$). This result is not described elsewhere and is likely to be a bias. Indeed, in large studies, no improvement in LVEF was shown in the short term, although an improvement may be observed in the long term [12]. It is possible that this improvement of LVEF is related to our population with almost exclusively ischemic heart disease managed shortly after an acute episode. The improvement of LVEF may be related to a natural evolution of heart failure on ischemic heart disease after an acute episode (reversion of myocardial sideration, effect of acute treatment, etc.).

Finally, the patient's psychological state also seemed to improve ($p=0.01$). This result corroborates with that of Blumenthal et al. which show an improvement in the anxiety-depressive state [13].

This current picture of the results obtained in the rehabilitation of heart failure at the Wattrelos site is similar with the results published in numerous studies. This is reassuring for the validation of the established protocols, even if they still need to be improved. However, it is necessary to verify whether these effects persist, and this is the goal of our work detailed in the following chapter.

➤ Long-term study of cardiac rehabilitation

In our series, the follow-up shows 8% of mortality rate at 19 months and 28% of rehospitalization for cardiovascular causes. In the Framingham Heart and the Hillingdon Heart Failure Studies, the mortality rate at one and five years after the diagnostic of heart failure was 30% and 65%, respectively. In the Rotterdam Study, the mortality rate was lower with 11%, 21% and 41% at one, two and five years, respectively [27]. The mortality rate was 28% in the Coach Study, in which 35% of patients were rehospitalized at least once over 18 months for a cardiovascular cause [22]. In our study, the mortality rates are lower than those of the literature data. These differences in the mortality rate could be due to the recruitment of relatively less severe patients in our study than in the other studies. On the other hand, our rehospitalization rate is quite comparable, and we find the usual evolution and follow-up of a population of heart failure patients.

Somewhat surprised by such variable findings more or less old studies, we have decided to include some data from large, rigorous, and landmark studies in the treatment of heart failure: in SOLVD-T, the mortality with enalapril was 11.2% per 100 patient-years; in the CHARM Study, with candesartan, the mortality was 8.2 per 100 patient-years; in the PARADIGM-HF study, with LCZ696, the mortality was 6 per 100 patient-years [28].

Certainly, we cannot compare our 30-patient study with studies involving numbers of more than 1000 patients: SOLVD-T (1285 patients on enalapril), CHARM (1013 patients on candesartan). Nevertheless, it is valuable to note that our death rate at 18 months is within in the range of these studies.

On the other hand, our annual rehospitalization rate for cardiovascular causes was higher with 18% compared with 10.9 per cent per year in SOLVD-T on enalapril, 8.6 per cent per year in CHARM on candesartan, and 6.2 per cent per year in PARADIGM-HF. This rehospitalization frequency is striking. It is likely that patients are more compliant with the close monitoring in the rigorous and well-followed studies, and thus, may explain a lower rehospitalization rate.

More than half of the patients reported an improvement in quality of life (84%), of dyspnea (72%), and of knowledge of heart failure (92%) after rehabilitation. These results are considerably in agreement with those of the literature data [29 30].

When studying the questionnaire of medical workers, a trend quite similar to that of the patient questionnaire was found. In particular, the majority of physicians observed improvements of dyspnea (86%), of knowledge of the disease (73%), and of quality of life (100%) of their patients after rehabilitation. It is interesting to consider that the assessment made by the treating physician of his patient corresponds well to the patient's feeling; the treating physician remains the closest person to the patient, and he is the one who probably has the most precise vision of the regular evolution of this chronic disease.

For the evaluation of observance, the treating physician undoubtedly overestimates the observance of his patients. Thus, 91% of the doctors stated that their patients were observant, and this did not correspond exactly to real observation. In fact, 20% of patients had forgotten their medication in our study. This result is even slightly lower than the estimated 30-40% non-observance rate observed in the heart failure [31,32]. Therefore, the observance is clearly a major problem in heart failure as in all chronic diseases.

68% of the respondents thought that the physical exercise was essential, but only 15% of them were enrolled in a sports club. Through the questionnaire, only 44% seemed to maintain a regular physical activity.

In the literature, the data are worse: 30% of patients adhered to physical exercise at one year in the HF-Action study [22] and 39% in the COACH study [23].

In this analysis, the only variable that seemed to deteriorate in the post-rehabilitation period was the glycemia ($p=0.031$), the other variables remained at the same level. However, the post-rehabilitation increases level of the glycemia showed that physical activity was clearly reduced. Other studies have revealed an improvement in metabolic markers at 6 months [25]. We did not find any research study investigating the glycemia levels at a distance from rehabilitation. This change in the glycemic status of our study population indicates the difficulty of maintaining regular physical activity and optimal observance.

How can we identify the heart failure patients who will be the least active and the least compliant after their rehabilitation passages?

We tried to identify the predictive parameters of this potentially negative situation. Here are our results.

➤ **New insights provided by our study**

In our study, patients with stamina and motivation after rehabilitation are more compliant with physical exercises at a distance from the rehabilitation. The motivation is a variable whose importance for the continuation of physical exercise has been recognized in several studies [4,7]. The motivation is related to regular follow-up, group work, and pleasure or leisure-linked activities. These relationships were found several studies [4-6] where some of them even highlight the interest of "remotivation" at six months [18]. However, no guidelines have yet been developed by scholar societies [1, 2, 10, 34].

Many items, regarding the motivation and particularly its genesis, are still not investigated [4].

In the methodology, we explained how nurses and doctors determined the endurance for each patient. We recall it here because this data is important for the discussion. The patient is offered an increase workload and work power on the cycloergometer for a 30-minute effort duration. The patients who regularly manage to increase their work power during the 4 weeks of rehabilitation were considered enduring.

In our study, the endurance at the end of rehabilitation, a variable, was consistent with to the power that the patient managed to maintain. It was the result of a progression observed during the whole rehabilitation. In fact, it resulted from the sum of an effort performance and a motivation of the patient to progress. This is a new concept which is still not developed by current studies. For us, it correlates with a heart failure patient who "can" more and "wants" more. This variable could not be identified as endurance but rather the Observed Progress in Endurance (OPE).

In our study, the continuation of physical exercise at home does not seem to be linked to effort performances at the end of the rehabilitation, but rather to the OPE. Interestingly, the performance acquired during a rehabilitation session can be rapidly lost during a sedentary behavior of less than one month [11,35-37].

Some training modalities already identified are more preferable to others. So, could it be that a better OPE with other training modalities, especially with intermittent or combined endurance and resistance training?

The adherence was a major problem in heart failure as described in the introduction; however, motivation is only addressed by some studies. When motivation is discussed, its apprehension is difficult. Our study proposes a new method to approach motivation and to quantify it. This could be a process for assessing motivational methods.

In the other words, unmotivated and less enduring patients would need a reinforced follow-up associated with a group work at the end of a rehabilitation period. The follow-up will ideally be a direct follow-up by connected devices, measuring physical activity. Indeed, these devices are accessible nowadays because of their abundance, their easy use, and their cheap prices [277-279]. French products, such as connected T-shirts, have been developed to be perfectly adapted to professional or amateur sports activity [280]. Moreover, a French expertise has already demonstrated very promising and economically interesting results for remote monitoring of automatic implantable defibrillators [41,43]. These tools will allow attending physicians and cardiologists to supervise the activity of their heart failure patients equipped with pacemakers for cardiac resynchronisation therapy (CRT) and defibrillators with a single click in the future.

Moreover, patients should be advised to practice a physical activity that they enjoy. Ainsi, it will be necessary to favor moderate intramural physical activities without any competitive spirit after a personalized assessment [44].

In Europe, these physical activities are gymnastics, cycling, and running, which are ideally practiced in groups. In Asia, it may be efficiency activities, such as tai-chi, qi-gong, etc; however, dancing remains the physical activity of choice.

As a result, the patient can find a preferred physical activity that he will continuously perform.

For years, doctors involved in cardiac rehabilitation would like to prove the effectiveness of rehabilitation in this field. The studies are sometimes contradictory and the results were not satisfactory at 2 years in the HF-ACTION study. Undoubtedly, the loss of effectiveness resulted from a lack of observance.

Objectively, the physician should fight against the relapse to sedentary lifestyle as he fights against intra-stent restenosis.

Certainly, we will wait for the results of the French multicenter EMAP study, which will provide valuable information on the maintenance of physical activity in heart failure.

Finally, we must remain modest because physical activity and sport in healthy adults are already reduced: more than 50% of inactive people in the study of Wen CP et al. [45] and more than 30% according to the WHO [47,48].

Conclusion :

Our study shows that there are clinical and paraclinical benefits in the short-term ~~rehabilitation and at a distance from the~~ and long-term rehabilitation.

Only 44% of the participants have continued to exercise significantly ~~at the distance~~ of the rehabilitation.

Endurance at the end of rehabilitation and patient motivation seem to be the only variables related to the continuation of physical activity. This study highlights a new variable called the observed progress in ~~endurance~~ to identify the patients who will be the least observant or compliant.

It would seem that patients who are not motivated and have little stamina at the end of a rehabilitation period would require a close follow-up along with a group work and a practice of physical activity that they like. Further studies are needed to confirm and clarify these findings.

References

1. The Task Force for the diagnosis and treatment of acute and chronic heart failure 2008 of the European Society of Cardiology, Developed in collaboration with the Heart Failure Association of the ESC (HFA). ESC guidelines for the diagnosis and treatment of acute and chronic heart failure 2008. *Eur J Heart Fail.* 2008;10:933-89.
2. The Task Force for the Diagnosis and Treatment of Acute and, Chronic Heart Failure 2012 of the European Society of Cardiology, Developed in collaboration with the Heart Failure Association (HFA), of the ESC. ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012. *Eur Heart J.* 2012;33:1787-847.
3. Piepoli MF, Conraads V, Corrà U, Dickstein K, Francis DP, Jaarsma T, et al. Exercise training in heart failure: from theory to practice. A consensus document of the Heart Failure Association and the European Association for Cardiovascular Prevention and Rehabilitation. *Eur J Heart Fail.* avr 2011;13(4):347-57.
4. Conraads VM, Deaton C, Piotrowicz E, Santaularia N, Piepoli MF, Burkert P, et al. Adherence to exercise of heart failure patients: barriers and possible solutions. A position statement of the Study Group on Exercise Training in Heart Failure of the Heart Failure Association of the European Society of Cardiology. *Eur J Heart Fail.* 5(14):451-8.
5. Wal MHL van der, Jaarsma T, Moser DK, Veeger NJGM, Gilst WH van, Veldhuisen DJ van. Compliance in heart failure patients: the importance of knowledge and beliefs. *Eur Heart J.* 1 févr 2006;27(4):434-40.
6. O'Connor CM, Whellan DJ, Lee KL, Keteyian SJ, Cooper LS, Ellis SJ, et al. Efficacy and safety of exercise training in patients with chronic heart failure: HF-ACTION randomized controlled trial. *JAMA.* 8 avr 2009;301(14):1439-50.
7. Marzolini S, Brooks D, Oh PI. Sex differences in completion of a 12-month cardiac rehabilitation programme: an analysis of 5922 women and men. *Eur J Cardiovasc Prev Rehabil Off J Eur Soc Cardiol Work Groups Epidemiol Prev Card Rehabil Exerc Physiol.* déc 2008;15(6):698-703.
8. Bjarnason-Wehrens B, Grande G, Loewel H, Völler H, Mittag O. Gender-specific issues in cardiac rehabilitation: do women with ischaemic heart disease need specially tailored programmes? *Eur J Cardiovasc Prev Rehabil Off J Eur Soc Cardiol Work Groups Epidemiol Prev Card Rehabil Exerc Physiol.* avr 2007;14(2):163-71.
9. Beckie TM, Beckstead JW. Predicting cardiac rehabilitation attendance in a gender-tailored randomized clinical trial. *J Cardiopulm Rehabil Prev.* juin 2010;30(3):147-56.
10. Coats AJS, Adamopoulos S, Meyer TE, Conway J, Sleight P. Effects of physical training in chronic heart failure. *The Lancet.* 13 janv 1990;335(8681):63-6.

11. Smart N, Fang ZY, Marwick TH. A practical guide to exercise training for heart failure patients. *J Card Fail.* févr 2003;9(1):49-58.
12. Belardinelli R, Georgiou D, Cianci G, Purcaro A. 10-year exercise training in chronic heart failure: a randomized controlled trial. *J Am Coll Cardiol.* 16 oct 2012;60(16):1521-8.
13. McKelvie RS, Teo KK, Roberts R, McCartney N, Humen D, Montague T, et al. Effects of exercise training in patients with heart failure: the Exercise Rehabilitation Trial (EXERT). *Am Heart J.* juill 2002;144(1):23-30.
14. Boesch C, Myers J, Habersaat A, Ilaraza H, Kottman W, Dubach P. Maintenance of exercise capacity and physical activity patterns 2 years after cardiac rehabilitation. *J Cardpulm Rehabil.* févr 2005;25(1):14-21; quiz 22-3.
15. Wittmer M, Volpatti M, Piazzalonga S, Hoffmann A. Expectation, satisfaction, and predictors of dropout in cardiac rehabilitation. *Eur J Prev Cardiol.* oct 2012;19(5):1082-8.
16. Sanderson BK, Phillips MM, Gerald L, DiLillo V, Bittner V. Factors associated with the failure of patients to complete cardiac rehabilitation for medical and nonmedical reasons. *J Cardpulm Rehabil.* août 2003;23(4):281-9.
17. Chien H-C, Chen H-M, Garet M, Wang R-H. Predictors of physical activity in patients with heart failure: a questionnaire study. *J Cardiovasc Nurs.* juill 2014;29(4):324-31.
18. Tierney S, Mamas M, Woods S, Rutter MK, Gibson M, Neyses L, et al. What strategies are effective for exercise adherence in heart failure? A systematic review of controlled studies. *Heart Fail Rev.* janv 2012;17(1):107-15.
19. Société Française de Cardiologie. Newsletter - Juin 2014 [Internet]. [cité 4 mars 2015]. Disponible sur: <http://www.sfcadio.fr/newsletter-juin-2014>
20. Jaarsma T, van der Wal MHL, Lesman-Leegte I, Luttik M-L, Hogenhuis J, Veeger NJ, et al. Effect of moderate or intensive disease management program on outcome in patients with heart failure: Coordinating Study Evaluating Outcomes of Advising and Counseling in Heart Failure (COACH). *Arch Intern Med.* 11 févr 2008;168(3):316-24.
21. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand.* juin 1983;67(6):361-70.
22. Jaarsma T, van der Wal MHL, Lesman-Leegte I, Luttik M-L, Hogenhuis J, Veeger NJ, et al. Effect of moderate or intensive disease management program on outcome in patients with heart failure: Coordinating Study Evaluating Outcomes of Advising and Counseling in Heart Failure (COACH). *Arch Intern Med.* 11 févr 2008;168(3):316-24.

23. Grace SL, Gravely-Witte S, Kayaniyil S, Bruhal J, Suskin N, Stewart DE. A multisite examination of sex differences in cardiac rehabilitation barriers by participation status. *J Womens Health* 2002. févr 2009;18(2):209-16.
24. Evenson KR, Johnson A, Aytur SA. Five-year changes in North Carolina outpatient cardiac rehabilitation. *J Cardpulm Rehabil.* déc 2006;26(6):366-76.
25. Kubilius R, Jasiukevičienė L, Grižas V, Kubilienė L, Jakubsevičienė E, Vasiliauskas D. The impact of complex cardiac rehabilitation on manifestation of risk factors in patients with coronary heart disease. *Med Kaunas Lith.* 2012;48(3):166-73.
26. Schwaab B, Waldmann A, Katalinic A, Sheikhzadeh A, Raspe H. In-patient cardiac rehabilitation versus medical care - a prospective multicentre controlled 12 months follow-up in patients with coronary heart disease. *Eur J Cardiovasc Prev Rehabil Off J Eur Soc Cardiol Work Groups Epidemiol Prev Card Rehabil Exerc Physiol.* août 2011;18(4):581-6.
27. Mosterd A, Hoes AW. Clinical epidemiology of heart failure. *Heart Br Card Soc.* sept 2007;93(9):1137-46.
28. McMurray J, Packer M, Desai A, Gong J, Greenlaw N, Lefkowitz M, et al. A putative placebo analysis of the effects of LCZ696 on clinical outcomes in heart failure. *Eur Heart J.* 14 févr 2015;36(7):434-9.
29. Edelmann F, Grabs V, Halle M. [Exercise training in heart failure]. *Internist.* juin 2014;55(6):669-75.
30. Lloyd-Williams F, Mair FS, Leitner M. Exercise training and heart failure: a systematic review of current evidence. *Br J Gen Pract J R Coll Gen Pract.* janv 2002;52(474):47-55.
31. Nieuwenhuis MMW, Jaarsma T, van Veldhuisen DJ, van der Wal MHL. Self-reported versus « true » adherence in heart failure patients: a study using the Medication Event Monitoring System. *Neth Heart J Mon J Neth Soc Cardiol Neth Heart Found.* août 2012;20(7-8):313-9.
32. Calvin JE, Shanbhag S, Avery E, Kane J, Richardson D, Powell L. Adherence to evidence-based guidelines for heart failure in physicians and their patients: lessons from the Heart Failure Adherence Retention Trial (HART). *Congest Heart Fail Greenwich Conn.* avr 2012;18(2):73-8.
33. De Maeyer C, Beckers P, Vrints CJ, Conraads VM. Exercise training in chronic heart failure. *Ther Adv Chronic Dis.* mai 2013;4(3):105-17.
34. Gibbons RJ, Balady GJ, Bricker JT, Chaitman BR, Fletcher GF, Froelicher VF, et al. ACC/AHA 2002 guideline update for exercise testing: summary article: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1997 Exercise Testing Guidelines). *Circulation.* 1 oct 2002;106(14):1883-92.

35. Piña IL, Apstein CS, Balady GJ, Belardinelli R, Chaitman BR, Duscha BD, et al. Exercise and Heart Failure A Statement From the American Heart Association Committee on Exercise, Rehabilitation, and Prevention. *Circulation*. 3 avr 2003;107(8):1210-25.
36. Meyer K, Schwaibold M, Westbrook S, Beneke R, Hajric R, Görnandt L, et al. Effects of short-term exercise training and activity restriction on functional capacity in patients with severe chronic congestive heart failure. *Am J Cardiol*. 1 nov 1996;78(9):1017-22.
37. Willenheimer R, Rydberg E, Cline C, Broms K, Hillberger B, Öberg L, et al. Effects on quality of life, symptoms and daily activity 6 months after termination of an exercise training programme in heart failure patients. *Int J Cardiol*. janv 2001;77(1):25-31.
38. AirStrip Healthcare Without Boundaries [Internet]. Disponible sur: <http://www.airstriptechnology.com/>
39. AliveCore Heart Monitor [Internet]. Disponible sur: <http://www.alivecore.com/home>
40. Le micro-capteur ingérable [Internet]. Disponible sur: <http://www.proteus.com/>
41. Cityzen Sciences : Le spécialiste des Textiles connectés [Internet]. Cityzen, le spécialiste des textiles connectés. Disponible sur: <http://www.cityzensciences.fr/>
42. Guédon-Moreau L, Lacroix D, Sadoul N, Clémenty J, Kouakam C, Hermida J-S, et al. Costs of remote monitoring vs. ambulatory follow-ups of implanted cardioverter defibrillators in the randomized ECOST study. *Eur Eur Pacing Arrhythm Card Electrophysiol J Work Groups Card Pacing Arrhythm Card Cell Electrophysiol Eur Soc Cardiol*. août 2014;16(8):1181-8.
43. Morichau-Beauchant T, Boulé S, Guédon-Moreau L, Finat L, Botcherby EJ, Périer M-C, et al. Remote monitoring of patients with implantable cardioverter-defibrillators: can results from large clinical trials be transposed to clinical practice? *Arch Cardiovasc Dis*. déc 2014;107(12):664-71.
44. Carré F. Insuffisance cardiaque chronique. Compte rendu du XXème congrès du CNCH, Groupe insuffisance cardiaque. 2015 mars p. 19.
45. Wen CP, Wai JPM, Tsai MK, Yang YC, Cheng TYD, Lee M-C, et al. Minimum amount of physical activity for reduced mortality and extended life expectancy: a prospective cohort study. *The Lancet*. 7 oct 2011;378(9798):1244-53.
46. OMS | Recommandations mondiales en matière d'activité physique pour la santé [Internet]. WHO. Disponible sur: http://www.who.int/dietphysicalactivity/factsheet_recommendations/fr/
47. OMS | Activité physique [Internet]. WHO.