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Evaluation of Health Status For Myocardial Infarction Patients at Misan Center For Cardiac Diseases And Surgery in AL-Amara City

A Graduation Research Submitted

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For

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بسم الله الرحمن الرحيم

﴿وَقُلِ اعْمَلُوا فَسَيَرَى اللَّهُ عَمَلَكُمْ وَرَسُولُهُ

صلى

وَالْمُؤْمِنُونَ وَسَتُرَدُّونَ إِلَىٰ عَالِمِ الْغَيْبِ

وَالشَّهَادَةِ فَيُنَبِّئُكُمْ بِمَا كُنتُمْ تَعْمَلُونَ﴾

صدق الله العلي العظيم

سورة التوبة_ الآية (١٠٥)

الاهداء

الى فتيات الحي المهمشات الى كل أنثى حلمها لم يكتمل خلف جدران القبيلة .الى كل الجدائل المبتورة تحت قوانين و تعاقيد العشيرة. قالوا من الخطأ ان الفتاة تتعلم ليضعوا لها قيود وسلاسل .هم فقط كانوا يخشونها لأنها عظيمة جدا .

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Abstract:

Background: It is known that cardiovascular diseases are the main causes of morbidity and mortality in the world today and Acute Myocardial Infarction (AMI) is one of the main causes. The patient with AMI reduces activities of daily living and work and may even impact their health status and quality of life.

Objective(s): The objectives of present study is to evaluate the health status for myocardial infarction patients at Misan center for cardiac diseases and surgery in Al-Amara city.; and to identify the relationship between the myocardial infarction patients and their socio-demographic characteristics.

Methods: The descriptive design is performed during the present study in the Misan center for the cardiac diseases and surgery in Al-Amara city/ Iraq. For the period of December 20th, 2020 to August 10th, 2021. Probability "random" sample of (120) patients with myocardial infarction are selected. The sheet of questionnaire is consist of two major portions (socio-demographic characteristics and health status of myocardial infarction patients part). Data collection are taken by use this adopted questionnaire (in the Arabic version), and the use of pattern interview way for each myocardial infarction patient. Reliability of the instrument through test-retest of this tool, it was determined by utilizing the Cronbach's alpha for the pilot study was r= 0.92, and the validity of the tools content determined based on the search patched by experts. The data for this study is analyzed via the use the SPSS version 24. Through descriptive statistics (frequencies, percentages, Arithmetic mean, mean of score, and standard deviations), and inferential statistical (Chi-square test).

Results: The outcomes of study depict the majority of participants have a moderate level of health status evaluation regarding myocardial infarction patients at the study sample (n=120; 77(64.2%), with mean and standard deviation (2.13 ± 0.326).; The current study is showed a clear effect for the clinical features such as (duration of disease and chronic diseases) on health status for myocardial infarction patients.

Conclusion: The current study concluded that an overall evaluation for myocardial infarction patients' health status was moderate level. It is clear to myocardial infarction can decrease health status and quality of life, so that limit a person's effectiveness in community participation.

Recommendation: The study recommended that educational programs and health awareness programs be provided for myocardial infarction patients, and an emphasis on follow-up and periodic investigations within medical health, which will improve the quality of life in future to good level.

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List of abbreviations

No.	Abb. & Symbols	Meaning
1	MI	Myocardial infarction
2	UNA	Unstable Angina
3	U.S	.United States
4	AMI	Acute Myocardial Infarction

5	HRQoL	health-related quality of life
6	MIDAS	myocardial infarction dimensional assessment scale
7	PCS	physical component score
8	CAD	coronary artery disease
9	SF-12	Short Form-12
10	EQ-5D	EuroQoL
11	SAQ	Seattle angina questionnaire
12	BRFSS	Behavioral Risk Factor Surveillance System
13	BMI	body mass index
14	EQ-5D VAS	EuroQol-5D Visual Analog Scale
15	SPSS	Statistical package for Social Sciences
16	SD	Standard Deviation

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CHAPTEAR ONE

INTRODUCTION

Chapter One

1. Introduction

It is known that cardiovascular diseases are the main causes of morbidity and mortality in the world today and Acute Myocardial Infarction (AMI) is one of the main causes. The patient with AMI reduces activities of daily living and work and may even impact their health status and quality of life (Andrade AS et al., 2018). Acute Myocardial Infarction, which is characterized by the presence of atherosclerosis, which is the accumulation of fat plaques in the arteries over the years that block the passage of blood (Mertins, 2016).

According to the INTERHEART study report, nine factors are responsible for 90% of myocardial infarctions. Modifiable risk factors include Diabetes mellitus, smoking, hypertension, hyperlipidemia, sedentary life style, obesity, stress and depression. The combination of several risk factors further enhances the risk (Azab, A. E., & Elsayed, A. S. , 2017).

The most prevalent risk factor for MI in male and female patients is diabetes. Smoking is the second risk factor in males, and hypertriglyceridemia was the second risk factor among female patients (Sinha, S. K., et al., 2017).

After AMI the individual is limited to performing some activities both physical and daily life, as they can harm the heart and cause a new AMI. Because of this, cardiac rehabilitation should be started immediately In general, 60 days after discharge from the hospital such activities can be performed، but it is necessary to tart gradually and, first of all, to perform exams such as exercise testing and echocardiography (Siervuli, 2014).

Physical therapy has been considered a fundamental component in the rehabilitation of patients with cardiovascular diseases in order to improve

cardiovascular conditioning and prevent thromboembolic events and analgesic postures. It offers greater physical independence and safety for hospital discharge and subsequent recovery of activities of daily living (Leite et al., 2009). Because the pathology of AMI in bed for three weeks for myocardial scarring thereby causing loss of functionality and quality of life such as orthostatism and ambulation (Fuochi G, & Foa C, 2017).

Cardiac rehabilitation is a sum of activities performed with cardiopathy patients that aim at improving physical psychological and social conditions (Andrade AS et al., 2018).

Short-term mortality following acute myocardial infarction (AMI) has diminished significantly over the last decade. Consequently, a greater proportion of clinical events affecting these patients include longer-term outcomes with cost and health status implications, such as rehospitalizations for unstable angina (UA) or unplanned coronary revascularization. Readmission rates have attracted major attention by payers and regulators in recent years, such that rehospitalization after AMI is now considered a marker of poor healthcare (Shore S. et al., 2014).

1.2. Importance of the Study

Each year, approximately 735,000 people in the United States (U.S.) experience a myocardial infarction (MI) making it one of the leading causes of death and disability. Of these, 525,000 are new attacks and 210,000 are recurrent attacks. With the advent of reperfusion and preventative therapies, short-term mortality following MI has decreased (Mozaffarian D. et al., 2015).

Complications after MI are well documented and include a higher risk of additional cardiovascular events such as heart failure, angina, arrhythmias, stroke, or death (Khan MG, 2005).

The most important predictors of subsequent patients outcome after acute myocardial infarction (AIM) are infarct size, left ventricular ejection fraction, left ventricular volumes and presence and extent of residual myocardial ischemia (Meijer A et al., 2011).

Importantly, assessing health-related quality of life (HRQoL) has value in determining which individual characteristics are related to reduced HRQoL so that clinicians can identify possible interventions to relieve symptoms, prolong life, improve functionality, and increase participation in activities of daily living (Boini S. et al., 2006).

The myocardial infarction survivors experienced lower HRQoL on domains of general health, physical health, and mental health compared to the general population when controlling for some known predictors of reduced quality of life after myocardial infarction. There were no differences in MI survivors and the general population on domains of recommended sleep, emotional support, or life satisfaction. Clinical interventions focused on physical functioning, activities of daily living, and improving access to mental health services may improve health status among MI survivors in the U.S. (Mollon, L., & Bhattacharjee, S. , 2017).

Myocardial infarction (MI) is a severe life event followed by an increased risk of mental health problems such as depression, anxiety and low mental health status. Several studies have shown that depression and anxiety after MI are associated with a higher risk of cardiovascular events and death, but much less is known about the impact of broader measures of mental health (Nielsen, T. J., et al., 2013).

1-3. Statement of the Problem :

The statement of the present study the evaluation of health status for myocardial infarction patients at Misan center for cardiac diseases and surgery in Al-Amara city.

1.4. Objectives of the Study:

1. To evaluate the health status for myocardial infarction patients at Misan center for cardiac diseases and surgery in Al-Amara city.

2. To identify the relationship between the myocardial infarction patients and their socio-demographic characteristics (age, gender, residence, level of education, marital status, occupation status, monthly income, socio-economic status).

3. To found out the association between the myocardial infarction patients and their clinical characteristics (duration of disease and chronic diseases).

1.5. Hypotheses : We hypothesize that the results may reveal;

1. Significant differences between myocardial infarction patients and their demographic characteristics.
2. Significant differences among myocardial infarction patients and their clinical characteristics.

1.6. Definition of term.

1.6.1. Evaluation:

1.6.1.a. Theoretical Definition:

Is a systematic determination of a subject's merit, worth and significance, using criteria governed by a set of standards. It can assist an organization, program, design, project or any other intervention or initiative to assess any aim, realisable concept/proposal, or any alternative, to help in decision-making; (Nadin, M., 2016).

1.6.2.b. Operational Definition:

Give the degree of achievement or value in regard to the aim and objectives and results of any such action that has been completed.

1.6.2. Health Status:

1.6.2.a. Theoretical Definition:

A state of complete physical, mental and social well-being, and not " merely the absence of disease". Health can be considered in terms of a person's body structure and function and the presence or absence of disease or signs (WHO, 2000).

1.6.1.b. Operational Definition:

Broad measures of the physical, mental and social well-being of individuals. Examples include self-rated health, self-esteem. Indicators in this framework.

1.6.3. Myocardial Infarction:

1.6.3.a. Theoretical Definition:

Commonly known as a heart attack, occurs when blood flow decreases or stops to a part of the heart, causing damage to the heart muscle (Adel Al-Tawaty, 2018).

1.6.3.b. Operational Definition:

is the irreversible death (necrosis) of heart muscle secondary to prolonged lack of oxygen supply (ischemia).

1.6.4. Patient:

1.6.4.a. Theoretical Definition:

Is any recipient of health care services that are performed by healthcare professionals. The patient is most often ill or injured and in need of treatment by a physician, nurse, psychologist, dentist, veterinarian, or other health care provide (Kohn et al., 2000).

1.6.4.b. Operational Definition:

Any person suffer from structural, functional and mental problems if presence or absence of disease or signs

CHAPTER TWO

REVIEW OF LITERATURE

Chapter Two

Review of Literatures

2. Previous Studies

2.1. Development and validation of a short measure of health status for individuals with acute myocardial infarction: The myocardial infarction dimensional assessment scale (Thompson, D.et al., 2000)

The purpose of this study was to develop and validate a disease-specific health status measure for individuals with myocardial infarction (MI). The development of the myocardial infarction dimensional assessment scale (MIDAS) followed three main stages. Stage 1 consisted of in-depth, semi-structured, exploratory interviews conducted on a sample of 31 patients to identify areas of salience and concern to patients with MI. These interviews generated 48 candidate questions. In stage 2 the 48-item questionnaire was used in a postal survey to identify appropriate rephrasing/shortening, to determine acceptability and to help identify sub-scales of the instrument addressing different dimensions of MI. Finally, in stage 3 the construct validity of MIDAS subscales was examined in relation to clinical and other health outcomes. A single center (district general hospital) in England was used to stages 1 and 3 and a national postal survey was conducted for stage 2. A total of 410 patients were recruited for the national survey (stage 2). Full data were available on 348 (85%) patients. One hundred and fifty-five patients were recruited to test construct validity (stage 3). The MIDAS contains 35 questions measuring seven areas of health status: physical activity, insecurity, emotional reaction, dependency, diet, concerns over medication and side effects. The measure has high face, internal and construct validity and is likely to prove useful in the evaluation of treatment regimes for MI.

2.2. Physical function and independence 1 year after myocardial infarction: Observations from the Translational Research Investigating Underlying disparities in recovery from acute Myocardial infarction: Patients' Health status registry (Dodson, J. A.,el al., 2012)

Background: Acute myocardial infarction (AMI) may contribute to health status declines including "independence loss" and "physical function decline." Despite the importance of these outcomes for prognosis and quality of life, their incidence and predictors have not been well described.

Methods: We studied 2,002 patients with AMI enrolled across 24 sites in the TRIUMPH registry who completed assessments of independence and physical function at the time of AMI and 1 year later. Independence was evaluated by the EuroQol-5D (mobility, self-care, and usual activities), and physical function was assessed with the Short Form-12 physical component score. Declines in ≥1 level on EuroQol-5D and >5 points in PCS were considered clinically significant changes. Hierarchical, multivariable, modified Poisson regression models accounting for within-site variability were used to identify predictors of independence loss and physical function decline.

Results: One-year post AMI, 43.0% of patients experienced health status declines: 12.8% independence loss alone, 15.2% physical function decline alone, and 15.0% both. After adjustment, variables that predicted independence loss included female sex, nonwhite race, unmarried status, uninsured status, end-stage renal disease, and depression. Variables that predicted physical function decline were uninsured status, lack of cardiac rehabilitation referral, and absence of pre-AMI angina. Age was not predictive of either outcome after adjustment. **Conclusions**: >40% of patients experience independence loss or physical function decline 1 year after AMI. These changes are distinct but can occur simultaneously. Although some risk factors are not modifiable, others suggest potential targets for strategies to preserve patients' health status.

2.3. Gender Differences in the Trajectory of Recovery in Health Status Among Young Patients With Acute Myocardial Infarction(Dreyer, R. P., et al., 2015)

Background: Despite the excess risk of mortality in young women (≤55 years of age) after acute myocardial infarction (AMI), little is known about young women's health status (symptoms, functioning, quality of life) during the first year of recovery after an AMI. We examined gender differences in health status over time from baseline to 12 months after AMI.

Methods and Results: A total of 3501 AMI patients (67% women) 18 to 55 years of age were enrolled from 103 US and 24 Spanish hospitals. Data were obtained by medical record abstraction and patient interviews at baseline hospitalization and 1 and 12 months after AMI. Health status was measured by generic (Short Form-12) and disease-specific (Seattle Angina Questionnaire) measures. We compared health status scores at all 3 time points and used longitudinal linear mixed-effects analyses to examine the independent effect of gender, adjusting for time and selected covariates. Women had significantly lower health status scores than men at each assessment (all P values <0.0001). After adjustment for time and all covariates, women had Short Form-12 physical/mental summary scores that were −0.96 (95% confidence interval [CI], −1.59 to −0.32) and −2.36 points (95% CI, −2.99 to −1.73) lower than those of men, as well as worse Seattle Angina Questionnaire physical limitations (−2.44 points lower; 95% CI, −3.53 to −1.34), more angina (−1.03 points lower; 95% CI, −1.98 to −0.07), and poorer quality of life (−3.51 points lower; 95% CI, −4.80 to −2.22).

Conclusion: Although both genders recover similarly after AMI, women have poorer scores than men on all health status measures, a difference that persisted throughout the entire year after discharge.

2.4. Gender differences in pre-event health status of young patients with acute myocardial infarction: A VIRGO study analysis (Dreyer, R. et al., 2016)

Aims: We assessed gender differences in pre-event health status (symptoms, functioning, quality of life) in young patients with acute myocardial infarction (AMI), and whether or not this association persists following sequential adjustment for important covariates. We also evaluated the interaction between gender and prior coronary artery disease (CAD), given that aggressive symptom control is a cornerstone of care in those with known coronary disease.

Methods and Results: A total of 3,501 AMI patients (2,349 women) aged 18–55 years were enrolled from 103 United States/24 Spanish hospitals (2008–2012). Clinical/health status information was obtained by medical record abstraction and patient interviews. Pre-event health status was measured by generic [Short Form-12 (SF-12), EuroQoL [EQ-5D)] and disease-specific [Seattle angina questionnaire (SAQ)] measures. T-test/chi-square and multivariable linear/logistic regression analysis was utilized, sequentially adjusting for covariates. Women had more co-morbidities and significantly lower generic mean health scores than men [SF-12 physical health =43±12 vs. 46±11 and mental health= 44±13 vs. 48±11]; EQ-5D utility index=0.7±0.2 vs. 0.8±0.2, and visual analog scale=63±22 vs. 67±20, $P<0.0001$ for all. Their disease-specific health status was also worse, with more angina [SAQ angina frequency=83±22 vs. 87±18], worse physical function [physical limitation=78±27 vs. 87±21] and poorer quality of life [55±25 vs. 60±22, $P<0.0001$ for all]. In multivariable analysis, the association between female gender and worse generic physical/mental health persisted, as well as worse disease-specific physical limitation and quality of life. The interaction between gender and prior CAD was not significant in any of the health status outcomes.

Conclusion: Young women have worse pre-event health status as compared with men, regardless of their CAD history. While future studies of gender differences should adjust for baseline health status, an opportunity may exist to better address the pre-event health status of women at risk for AMI.

2.5. Health related quality of life among myocardial infarction survivors in the United States: a propensity score matched analysis (Mollon & Bhattacharjee, 2017)

Background: Little is known regarding the health-related quality of life among myocardial infarction (MI) survivors in the United States. The purpose of this population-based study was to identify differences in health-related quality of life domains between MI survivors and propensity score matched controls.

Methods: This retrospective, cross-sectional matched case-control study examined differences in health-related quality of life (HRQoL) among MI survivors of myocardial infarction compared to propensity score matched controls using data from the 2015 Behavioral Risk Factor Surveillance System (BRFSS) survey. Propensity scores were generated via logistic regression for MI survivors and controls based on gender, race/ethnicity, age, body mass index (BMI), smoking status, and comorbidities. Chi-square tests were used to compare differences between MI survivors to controls for demographic variables. A multivariate analysis of HRQoL domains estimated odds ratios. Life satisfaction, sleep quality, and activity limitations were estimated using binary logistic regression. Social support, perceived general health, perceived physical health, and perceived mental health were estimated using multinomial logistic regression. Significance was set at $p < 0.05$. **Results**: The final sample consisted of 16,729 MI survivors matched to 50,187 controls (n = 66,916). Survivors were approximately 2.7 times more likely to report fair/poor general health compared to control (AOR = 2.72, 95% CI: 2. 43–3.05) and 1.5 times more likely to report limitations to daily activities (AOR

= 1.46, 95% CI: 1.34–1.59). Survivors were more likely to report poor physical health >15 days in the month (AOR = 1.63, 95% CI: 1.46–1.83) and poor mental health >15 days in the month (AOR = 1.25, 95% CI: 1.07–1.46) compared to matched controls. There was no difference in survivors compared to controls in level of emotional support (rarely/never: AOR = 0.75, 95% CI: 0.48–1. 18; sometimes: AOR = 0.73, 95% CI: 0.41–1.28), hours of recommended sleep (AOR = 1.14, 95% CI: 0.94–1.38), or life satisfaction (AOR = 1.62, 95% CI: 0.99–2.63).

Conclusion: MI survivors experienced lower HRQoL on domains of general health, physical health, daily activity, and mental health compared to the general population

2.6. Quality of Life in Patients after Acute Myocardial Infarction (Andrade AS et al., 2018)

Background: It is known that cardiovascular diseases are the main causes of morbidity and mortality in the world today and Acute Myocardial Infarction (AMI) is one of the main causes. The patient with AMI reduces activities of daily living and work and may even impact their quality of life. **Objective**: To analyze the quality of life in patients after acute myocardial infarction. Methodology: This is an observational study that was performed with patients admitted to the Noble Institute of Cardiology. After hospital admission, the patients were submitted to an evaluation of the quality of life through the SF-36 and the functionality through the Barthel scale.

Results: During the study period, 22 patients were evaluated: 16 (73%) men, mean age 61 ± 13 years. All SF-36 domains experienced a significant reduction with the exception of pain, limited by physical and emotional aspects. Functional capacity from 100 to 53 ± 18 (p=0.02), Physical aspects limitation from 100 to 61 ± 49 (p 0.10), Pain from 100 to 89 ± 17 (p=0.11), General status (P=0.03), Vitality from 100 to 52 ± 2 (p=0.02), Social aspects from 100 to 63 ±

24 (p=0.02), Emotional Aspects of 100 for 52 ± 30 (0.06), Mental Health from 100 to 77 ± 3 (p003D0.02). In addition, there was a reduction in functionality reducing from 100 to 70 ± 14 (p<0.001).

Conclusion: It can be concluded that there is a reduction of quality of life and functionality in patients after AMI.

2. 7. Health Status Outcomes in Acute Myocardial Infarction Patients Following Rehospitalization (Shore et al., 2018)

Background: Rehospitalizations following acute myocardial infarction (AMI) for unplanned coronary revascularization and unstable angina (UA) are common. However, despite the inclusion of these events in composite endpoints of many clinical trials, their association with health status has not been studied. **Methods and Results—**We included 3,283 AMI patients enrolled in a prospective, 24-center U.S. study who had rehospitalizations independently classified by experienced cardiologists. Health status was assessed using Seattle Angina Questionnaire (SAQ) and EuroQol-5D Visual Analog Scale (EQ-5D VAS). In the propensity-matched cohorts, one-year health status was compared between those who did and did not experience rehospitalization for UA or revascularization using a hierarchical linear model. Overall, mean age was 59 years, 33% were female and 70% were Caucasian. Rehospitalization rates for UA and unplanned revascularization at 1 year were 4.3% and 4.7%. One-year SAQ summary scores were worse in patients with rehospitalizations for UA.

Conclusions: Within the first year after AMI, rehospitalizations for UA and unplanned revascularization are associated with worse health status. These findings highlight the impact of such events from a patient's perspective, beyond their economic impact, and support the use of UA and unplanned revascularization as components of composite endpoints.

CHAPTER Three

Methodology

Chapter Three

3. Methodology

3.1. Design of the Study:

A descriptive design is carried throughout the present for the period from December **20th, 2020 to August 10th, 2021** to evaluate health status for patients' myocardial infarction at Misan center for cardiac diseases and surgery in AL-Amara city.

3.2. Administrative arrangements:

After submitted a request to the Dean of the College of Nursing regarding addressing the management of the Misan Center For Cardiac Diseases And Surgery in AL-Amara City about facilitating the task of collecting samples entitled facilitating the task and status of receiving the book for the management of the heart center to facilitate the task of researchers in all samples inside the approved center.**(Appendix B)**

3.3. Setting of the Study:

In order to obtain valid and comprehensive data the study is conducted at Misan Center For Cardiac Diseases And Surgery in AL-Amara City

3.4. Study sample:

A non-probability purposed sample of (120) patients who had diagnosed with myocardial infarction were selected for the purpose of this study.

3.4.1. Inclusion criteria.

1. Patients were diagnosed with myocardial infarction.

2. Patients were male and female.

3. Period of disease of the patients were six months and more.

4 -All patients are reviewing for follow-up in Misan Center For Cardiac Diseases And Surgery in AL-Amara City.

3.4.2. Exclusion criteria

1 . Patients who refused to participate in the study.

2. Patients with an disease period of less than six months

2. Exclude all patients without myocardial infarction

3.5. Selection of the sample

The sample population was selected for patients who fulfilled the conditions and diagnosed with myocardial infarction Misan Center For Cardiac Diseases And Surgery in AL-Amara City

3.6. The Study Instrument:

For the purpose of completing the current study, a questionnaire was adopted, to evaluate the health status of patients with myocardial infarction and data collected via use the developed questionnaire (in the Arabic version), where the method of structured interview for each patient was used as a data collection strategy. The research questionnaire consists of two basic aspects, which are as follows:**(Appendix A)**

Part l :Socio-demographic characteristics:

The first part of the questionnaire is related to socio-demographic characteristics and include (11) items of (age, gender، level of education, Occupational status, property (home, car), crowding index, monthly income, Suffering from chronic diseases.

part II: The Questionnaire Sheet for the Evaluation of Health Status For Patients' Myocardial Infarction

It consist of (29)items and distribute in four domains which include (physical status , mental and psychological status, social status, and behavioral status)

a. Physical status: It consist of (11) items concerned assessment of physical health, including all abilities to perform daily functions.

b. Mental and psychological status: It contain (8) items, focusing on all psychological and mental conditions that the patient may suffer from.

c. Social status: It composed of (5) items

d. Behavioral status: It include (5) items focuses on all patients' behavior.

3.7. Validity of the Questionnaire

The ideal procurement was based on the search patched by experts.

3.8 . Methods of data collection :

After obtaining permission from the cardiac diseases and surgery in AL-Amara City. Data were collected for the original study by applying a adopted questionnaire and the corresponding technique as a means of data set. Collecting information on each patient took about 20 minutes. The Data collection began from January, 24th,2021 to May,6th,2021.

3.9. Pilot Study:

A pilot study was conducted on samples (10) of patients who were excluded from the study sample to determine the reliability of the questionnaire The study aimed at :

a. Obtaining the clarity and the content adequacy of the questionnaire and observation.

b. Estimating the time required for the data collection.

c. Identifying the barriers that may be encountered during the data collection process

3.10. Reliability of the Questionnaire

Reliability is concerned with the consistency and dependability of the research instrument. Determination of reliability of the questionnaire is based on Cronbach's alpha reliability, the result of evaluation of the health status for patients with myocardial infarction is (29) items (r= 0.92). The results of the pilot study indicate that the instrument is adequately reliable for the present study.

3.11 . Statistical Analysis:

Data are analyzed through the use of SPSS (Statistical package for Social Sciences) version 24.0 application Statistical analysis system and Excel application the following statistical data analysis approaches were used in order to analyze and assess the results of the study:

3.11.1. Descriptive data analysis:

1- Tables (Frequencies and Percentages) with comparison significant.

$$\% = \frac{\text{Frequencies}}{\text{Sample size}} \times 100$$

2- Summary Statistics tables including: Arithmetic Mean **($\bar{x}$)** with their Standard Deviation (S.D), and their assessment by cutoff point (0.66) due to scores : Rate of score for these paragraphs were in accordance with the Likers' Scale: agree (3); uncertain (2); and disagree (1). Scores of response are categorized according to the following :

Good = (2.34- 3.00):3

Moderate = (1.67-2.33):2

Low = (1.00-1.66):1

$$M.S = \frac{\sum ri=1Fi \times Si}{\sum ri= 1Fi}$$

$$S.D = \sqrt{\frac{\sum (xi-x)^2 fi}{\sum fi}}$$

3- Arithmetic Mean ($\bar{x}$) and Std. Dev. (S.D.).

$$\overline{X} = \frac{\sum xi}{n}$$

3.11.II. Inferential data analysis:

These were used to accept or reject the statistical hypotheses, which included the following:

1- Chi-Square test for testing the different of distribution of the observed frequencies and their non-restricted of an expected outcomes .

$$X^2 = \sum \frac{(Oi-Ei)^2}{Ei}$$

X^2=chi-square

$\sum$= sum

Oi= frequency observation for a cell

Ei.= frequency expected for a cell.

3.12. Limitations of the Study :

The present study has experienced the following limitations :

1. The small sample size could be a major limitation of this study .

2. The lack of research and studies related to this study .

3. The finding of the study is limited only to the patients with myocardial infraction for cardiac diseases and surgery in AL-Amara.

Chapter Four

Results & Findings

4. Results and Findings

Table (1): Distribution of the myocardial infarction patients by their socio-demographic characteristics

No.	Variables	Characteristics	F	%
1.	Age (year)	30-39	9	7.5
		40-49	19	15.8
		50-59	39	32.5
		60-69	32	26.7
		70-79	21	17.5
		$\bar{x} \mp$ Std. Dev.	56.78 ± 11.507	
2.	Gender	Male	64	53.3
		Female	56	46.7
3.	Residence	Urban	77	64.2
		Rural	43	35.8
4.	Marital Status	Single	5	4.2
		Married	94	78.3
		Divorced	4	3.3
		Widowed	17	14.2
5.	Level of Education	Illiterate	31	25.8
		Read and Write	41	34.2
		Primary Graduate	20	16.7
		Intermediate Graduate	18	15.0
		Secondary Graduate	5	4.2
		Institute or College Graduate	5	4.2
6.	Occupation Status	High professional and managerial job	7	5.8
		Lower professional, skilled and semiskilled workers	28	23.3
		Unskilled workers	85	70.8
7.	Monthly Income	Enough	18	15.0
		Somewhat Enough	88	73.3
		Not Enough	14	11.7
8.	Socio-economic Status	Low	75	62.5
		Middle	41	34.2
		High	4	3.3

F= Frequencies , % = Percentages, Arithmetic Mean ($\bar{x}$) and Std. Dev.= Standard. Deviation.

The results of table (1) show that the approximately third of study sample concerning age group were within (50-59 years) it presented 39(32.5%), with arithmetic mean and standard deviation (**56.78 ± 11.507)**. also shows that the more half of participants 64(53.3%) were male. Addition, residence showed that more than half of participants were live urban as their percentage

reached 77(64.2%). With regard to marital status, it appears that more than three quarters of the sample were married 94(78.3%). In regarding to the subjects level of education, the results show that more than third of patients were read and write 41(34.3%). In addition, occupation status more than two-third of patients 85(70.8%) were unskilled workers. Addition, monthly income approximately three quarters of participants have somewhat enough as their percentage reached 88(73.3%). Socio-economic status of participants in study sample were more than of half in low level 75(62.5%).

Table (2): Distribution of the myocardial infarction patients by their clinical characteristics

No.	Variables	Characteristics	F	%
1.	Duration of disease	6 – 12 months	10	8.3
		1-2 years	51	42.5
		3-4 years	34	28.3
		5-6 years	18	15.0
		7-8 years	3	2.5
		≥ 9 years	4	3.3
2.	Chronic Diseases	None	18	15.0
		Hypertension	25	20.8
		Diabetes Mellitus	23	19.2
		Asthma	6	5.0
		Arthritis	2	1.7
		Hyperlipidemia	2	1.7
		Hypertension & Diabetes Mellitus	34	28.3
		Hypertension & Asthma	2	1.7
		Hypertension & Hyperlipidemia	3	2.5
		Hypertension & Liver fibrosis	1	0.8
		Diabetes Mellitus & Asthma	1	0.8
		Hypertension, Diabetes Mellitus & Asthma	3	2.5

No. = number of Variable , F= Frequencies , % = Percentages.

The results of this table show that the more of one-third of the study sample regarding duration of disease related to myocardial infarction patients were within (1-2 years) it presented 51(42.5%). Also in regarding to the subjects chronic diseases, the results show that quarter of sample were suffer from hypertension & diabetes mellitus 34(28.3%).

Table (3): Evaluation of the health status for patients with myocardial infarction in Al-Amara city

Items	Agree		Uncertain		Disagree		M.S.	S.D.	Eva.
	F	%	F	%	F	%			
A. Physical Status									
1. I suffer from one of the following diseases: diabetes, asthma, Hypertension, cholesterol.	103	85.8	11	9.2	6	5.0	**2.81**	0.507	**H**
2. I am gaining weight after being sick.	35	29.2	57	47.5	28	23.3	**2.06**	0.725	**M**
3. Inability to perform daily activities such as eating and bathing.	29	24.2	58	48.3	33	27.5	**1.97**	0.721	**M**
4. I suffer from digestive disorders.	73	60.8	32	26.7	15	12.5	**2.48**	0.710	**H**
5. I suffer from urinary disorders.	61	50.8	37	30.8	22	18.3	**2.32**	0.769	**M**
6. I suffer from pain in the body.	99	82.5	18	15.0	3	2.5	**2.80**	0.460	**H**
7. I feel tired.	98	81.7	21	17.5	1	.8	**2.81**	0.416	**H**
8. I have difficulty sleeping.	53	44.2	61	50.8	6	5.0	**2.39**	0.584	**H**
B. Mental and Psychological Status									
1. I have difficulty adapting to others.	28	23.3	60	50.0	32	26.7	**1.97**	0.709	**M**
2. I suffer from depression.	42	35.0	55	45.8	23	19.2	**2.16**	0.722	**M**
3. I have a feeling of sadness.	50	41.7	51	42.5	19	15.8	**2.26**	0.716	**M**
4. I have a feeling of helplessness.	41	34.2	60	50.0	19	15.8	**2.18**	0.686	**M**
5. I have a feeling of anger.	49	40.8	50	41.7	21	17.5	**2.23**	0.730	**M**
6. I suffer from anxiety and a sense of weakness and surrender to disease.	37	30.8	60	50.0	23	19.2	**2.12**	0.700	**M**
7. I suffer from emotional distress.	41	34.2	62	51.7	17	14.2	**2.20**	0.669	**M**
8. I have a feeling of despair.	44	36.7	52	43.3	24	20.0	**2.17**	0.737	**M**
9. I suffer from insecurity and fear of unknown	56	46.7	44	36.7	20	16.7	**2.30**	0.740	**M**
10. I suffer from memory disorders	36	30.0	55	45.8	29	24.2	**2.06**	0.737	**M**
11. I suffer from a lack of concentration.	42	35.0	58	48.3	20	16.7	**2.18**	0.698	**M**
C. Social Status									
1. I suffer from social discrimination.	29	24.2	57	47.5	34	28.3	**1.96**	0.726	**M**
2. I suffer from isolation and a sense of stigma.	21	17.5	63	52.5	36	30.0	**1.87**	0.681	**M**
3. I have difficulty interacting and communicating with others.	25	20.8	65	54.2	30	25.0	**1.96**	0.679	**M**
4. I suffer from disorders in the social relationship with family members.	27	22.5	56	46.7	37	30.8	**1.92**	0.729	**M**
5. I do not have the ability to make decisions.	27	22.5	58	48.3	35	29.2	**1.93**	0.719	**M**
D. Behavioral Status									
1. I am smoke (hookah or cigarette).	42	35.0	11	9.2	67	55.8	**1.79**	0.934	**M**
2. I am drinking alcohol.	10	8.3	9	7.5	101	84.2	**1.24**	0.594	**L**
3. I have a low physical activity.	41	34.2	46	38.3	33	27.5	**2.07**	0.786	**M**
4. I am taking narcotic drugs.	6	5.0	14	11.7	100	83.3	**1.22**	0.522	**L**
5. I practice unhealthy food behaviors (such as eating too much sugars or drinking soft drinks).	43	35.8	58	48.3	19	15.8	**2.20**	0.693	**M**

No. = number of item , F=frequencies , % = Percentages, M.S.= mean of score. Eva.= Evaluation;
Evaluation levels : (1.00-1.67) = Low; (1.68-2.33) = Moderate; (2.34-3.00) = High.

Table (3) reveals that there are moderate level of arithmetic mean in all items related to evaluate of health status regarding patients with myocardial infarction at the study sample, except items (1, 4, 6,7 & 8) related to physical status showed that high level of assessment of health status, while the items (2 & 4) related to behavioral status revealed that there is low level of assessment.

Table (4): Evaluation domains of health status for myocardial infarction patients

No	Main Domains Related to Health Status	Low		Moderate		Good		M.S.	Std. Dev.	Eva.
		F	%	F	%	F	%			
1	Physical Status	3	2.5	31	25.8	86	71.7	**2.46**	0.291	**H**
2	Mental and Psychological Status	19	15.8	48	40.0	53	44.2	**2.17**	0.487	**M**
3	Social Status	37	30.8	53	44.2	30	25.0	**1.92**	0.564	**M**
4	Behavioral Status	62	51.7	49	40.8	9	7.5	**1.70**	0.402	**M**
5	Overall Health status	10	8.3	77	64.2	33	27.5	**2.13**	0.326	**M**

No. = number of variable , F=frequencies , % = Percentages, M.S.= mean of score, Std. Dev.= standard deviation, Eva.= Evaluation; Evaluation levels : (1.00-1.67) = Low; (1.68-2.33) = Moderate; (2.34-3.00) = Good.

Results of the table (4) reveals that there are moderate level of mean score in all domains related to health status for myocardial infarction patients at the study sample, except physical status was good level of evaluation, while the majority of total overall of health status were moderate level (n=120; 77(64.2%), with mean of score and standard deviation (2.13 ± 0. 326).

Table (5): Overall evaluation of participants regarding health status

Levels of Evaluation	Frequency	Percent
Low : (1.00 - 1.66)	**10**	**8.3**
Moderate: (1.67 - 2.33)	**77**	**64.2**
High: (2.34 - 3.00)	**33**	**27.5**
Total	**120**	**100.0**
$\bar{x} \mp$ **Std. Dev**	**2.13 ± 0.326**	

Arithmetic Mean ($\bar{x}$) and Std. Dev.= Standard. Deviation.

This table reveals that the majority of participants have a moderate level of health status evaluation regarding myocardial infarction patients at the study sample (n=120; 77(64.2%), with mean and standard deviation (2.13 ± 0.326).

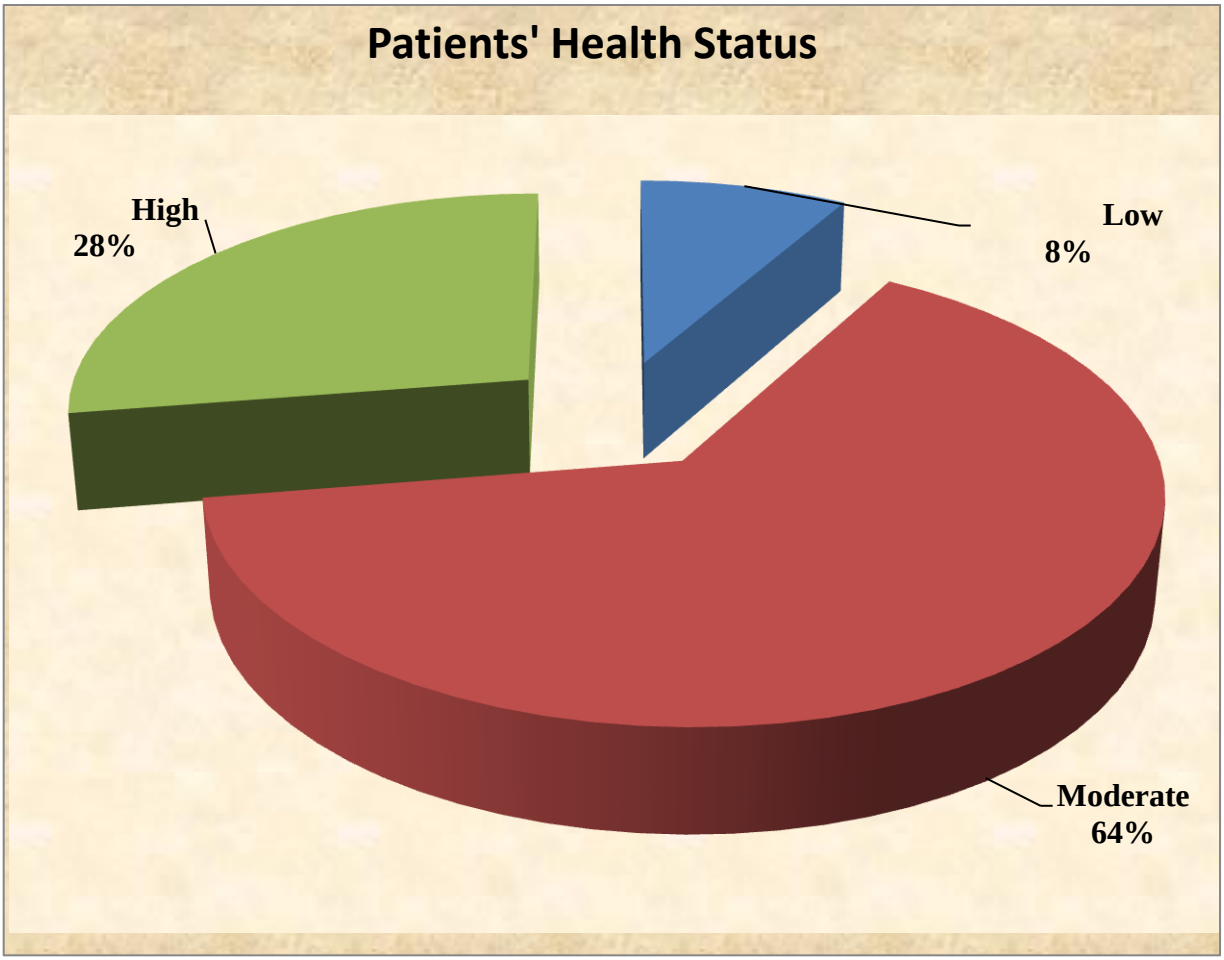
Table (6): Association Between health status patients with their Socio-demographic & Clinical Characteristics

Variables	$X^{2obs.}$	Df	P- value	Sig.
Age	26.011	8	**0.001**	**HS**
Gender	15.638	2	**0.000**	**HS**
Residence	27.067	2	**0.000**	**HS**
Marital Status	15.508	6	**0.017**	**S**
Level of Education	41.365	10	**0.000**	**HS**
Occupation Status	12.097	4	**0.017**	**S**
Monthly Income	16.381	4	**0.005**	**HS**
Socio-economic Status	15.480	4	**0.004**	**HS**
Duration of disease	25.981	10	**0.003**	**HS**
Chronic Diseases	39.884	12	**0.009**	**HS**

χ^2obs. = chi-square observed, χ^2crit = chi-square critical , df= degree of freedom, p = probability value, P < 0.05= significant, P < 0.01=High significant.

Table (6) indicates that there was a high significant relationship between health status for myocardial infarction patients with their socio-demographic and clinical characteristics in variables (age, gender, residence, level of education, monthly income, socio-economic status, duration of disease and chronic diseases) at (P < 0.01), while variables (marital status and occupation status), showed that there is a significant differences association at (P < 0.05), when analyzed by chi-square test.

Figure (1): Pie chart illustrate levels of health status regarding myocardial infarction patients



This figure reveals that the majority of participants have a moderate level of evaluation regarding health status for myocardial infarction patients at the study sample

CHAPTER FIVE

Discussion

Discussion

5. Discussion

This chapter deals with the interpretation of the results through the application to evaluate health status for patients with myocardial infarction, data had been analyzed and were interpreted according to the study objectives.

5.1. Part I: Discussion of the demographic characteristics of patients with myocardial infarction

Analysis of patients' demographic characteristics depicts the results of current study is showed that the approximately third of study sample concerning age group were within (50-59 years) it presented 39(32.5%), with arithmetic mean and standard deviation (56.78 ± 11.507). also shows that the more half of participants 64(53.3%) were male. This result is consistent with the findings of others, and the results of the study indicate that most patients' ischemic heart disease are within age (51 to 60) years old (Alkafaji, A. et al. ,2020). A total of 3,283 MI patients were analyzed; mean age was 59 years, 33% were female and 70% were Caucasian. In the year following the MI there were 144 (4.4%) re-hospitalizations for unplanned coronary revascularization and 140 (4.3%) for UA (Shore, S. et al. ,2014).

Addition, residence showed that more than half of participants were live urban as their percentage reached 77(64.2%). With regard to marital status, it appears that more than three quarters of the sample were married 94(78.3%). This finding was found to be consistent with the results of most other studies that found the majority of participants in study of coronary heart disease patients are males (56%), and (80%) are married and (44%) live in urban area (Janati, A. et al. ,2011).

In regarding to the subjects level of education, the results show that more than third of patients were read and write 41(34.3%). And (52.5 %)

persons with coronary artery disease are primary school graduate (or less) (Zamorano, J. et al., 2014). In addition, occupation status more than two-third of patients 85(70.8%) were unskilled workers.

Addition, monthly income approximately three quarters of participants have somewhat enough as their percentage reached 88(73.3%). Socio-economic status of participants in study sample were more than of half in low level 75(62.5%). (table-1) . A study revealed that most with ischemic heart diseases are unskilled workers (60.43%) and (75.82) somewhat enough monthly income (Dahal, P. et al. ,2000). Persons with ischemic heart disease in the lowest socio-economic status(Schultz, W. et al.,2018).

5.2. Part II: Discussion the distribution for the clinical characteristics of myocardial infarction patients

The results of this table show that the more of one-third of the study sample regarding duration of disease related to myocardial infarction patients were within (1-2 years) it presented 51(42.5%). Also in regarding to the subjects chronic diseases, the results show that quarter of sample were suffer from hypertension & diabetes mellitus 34(28.3%). This result is in an agreement with the studies by (Zamorano, J. et al., 2014 & Altaleb, F. et al., 2017) stated that found the majority of ischemic heart diseases patients had hypertension and diabetes mellitus.

5.3. Part III: Discussion the evaluation of the health status for patients with myocardial infarction

Table (3) reveals that there are moderate level of arithmetic mean in all items related to evaluate of health status regarding patients with myocardial infarction at the study sample, except items (1, 4, 6,7 & 8) related to physical status showed that high level of assessment of health status, while the items (2 & 4) related to behavioral status revealed that there is low level of evaluation. The data for this finding were presented to

be agreement with the results of other studies on life's quality that found that patients with ischemic cardiac disease had altered health status and goodness of life (Oldridge, N. et al., 2014). Results of current study reveals that there are moderate level of mean score in all domains related to health status for myocardial infarction patients at the study sample, except physical status was good level of evaluation, while the majority of total overall of health status were moderate level (n=120; 77(64.2%), with mean of score and standard deviation (2.13 ± 0. 326) (table-4). The majority of participants have a moderate level of health status evaluation regarding myocardial infarction patients at the study sample (n=120; 77(64.2%), with mean and standard deviation (2.13 ± 0.326) (table-5). Findings were presented to be agreement with the results (Azeez & Abdulhussein, 2021) reported state about quality of life among ischemic heart diseases patients in Misan center for the cardiac diseases and surgery in Al-Amara City .

5.4. Part IV: Discussion of the association between health status y for myocardial infarction patients and their socio-demographic features

Table (6) indicates that there was a high significant relationship between health status for myocardial infarction patients with their socio-demographic and clinical characteristics in variables (age, gender, residence, level of education, monthly income, socio-economic status, duration of disease and chronic diseases) at ($P < 0.01$), while variables (marital status and occupation status), showed that there is a significant differences association at ($P < 0.05$), when analyzed by chi-square test.

The outcome of current study is harmony with results authors (Azeez & Abdulhussein, 2021) that of the, which show that there is a statistical significant correlation among quality of life and health status for ischemic heart disease and demographic data. A another supportive evidence is

provided in the study which finds, that there are a significant relation between life's quality of cardiovascular patients, with their gender age, education, marital status, occupational status, suffering duration, residence, monthly income, and socio-economic status (Yaghoubi, A. et al., 2012). Thus, longer survival after MI increased the group of individuals at an produce risk of the complications affecting health status. A current study conducted in Germany revealed that health related to quality of life decreased significantly in MI survivors compared to the general people. Other study from (Mendes de Leon et al. Conducted in 1998) with a sample of elderly in Connecticut that showed a decrease in physical, psychological, and social functioning, particularly among the elderly (Mollon, L., & Bhattacharjee, S., 2017).

CHAPTER SIX

Conclusions And Recommendations

Chapter Six

6. CONCLUSIONS and RECOMMENDATION

6.1. Conclusions

1. The present study concluded that the overall evaluation to health status for patients suffer from myocardial infarction was within the moderate level.

2. The current study found that there is an impact of socio-demographic factors such as (age, gender, residence, level of education, occupational status, monthly income, socio-economic status) on the patients' health status with myocardial infarction

3. The current study is showed a clear effect for the clinical features such as (duration of disease and chronic diseases) on health status for myocardial infarction patients.

6.2. Recommendations

1. The study recommended that educational programs and health awareness programs be provided for myocardial infarction and ischemic heart patients.

2. Emphasis on follow-up and periodic examinations within medical health programs in accordance with the health institution's policy in accordance with international standards for recent sources and studies, which will improve their health status and quality of life in the future to a good level.

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APPENDIXES

Appendix A

الاستبانة

الجزء الاول - المعلومات الديموغرافية و الحالة الاجتماعية-الاقتصادية

١- العمر: ☐ سنة

٢- الجنس: ١. ذكر ☐ ٢. أنثى ☐

٣- الإقامة: ١. حضر ☐ ٢. ريف ☐

٤- مدة الاصابة بالمرض: ☐ **سنة**

٥- الحالة الزوجية:

١. أعزب ☐ ٢. متزوج ☐

٣. مطلق ☐ ٤. أرمل ☐

٦- المستوى التعليمي:

١. لا يقرأ ولا يكتب ☐ ٤. خريج الدراسة المتوسطة ☐

٢. يقرا ويكتب ☐ ٥. خريج الدراسة الإعدادية ☐

٣. خريج الدراسة الابتدائية ☐ ٦. خريج معهد أو كلية ☐

٧- المهنة :

١. وظيفة مهنية وإدارية عالية (طبيب، ضابط، ومدير أعمال ،أصحاب أملاك) ☐

٢. وظيفة مهنية أقل مهارة (معلم أو مدرس ، عامل كتابي ، صاحب شركة صغيرة ، رجل جيش أو شرطة) ☐

٣. العاملين غير المهرة (عامل يومي، سائق، بائع متجول، ،مزارع، عامل بعقد وقتي، كاسب ، متقاعد) ☐

٨- الملكية (المنزل، السيارة، ممتلكات الاسرة)

١. تملك منزل، (سيارة أو بدونها)، مع جميع ممتلكات الأسرة ☐

٢. منزل مؤجَّر، (سيارة أو بدونها)، مع وجود معظم مقتنيات الأسرة ☐

٣. منزل مشترك مع عائلة أخرى، (ولا توجد سيارة)، مع وجود بعض مقتنيات الأسرة ☐

٩- قياس مؤشر الاكتظاظ :

١. عدد أفراد الأسرة (الذين يعيشون في المنزل) ☐

٢. عدد الغرف في المنزل (باستثناء الحمام والمطبخ) ☐

١٠- الدخل الشهري: يكفي ☐ نوعاً ما يكفي ☐ لا يكفي ☐

١١- تعاني من الامراض المزمنة:

١. نعم ☐ ٢. كلا ☐

اذا كان الجواب نعم : اسم المرض ☐

الجزء الثاني : تقويم الحالة الصحية لمرضى احتشاء عضلة القلب:

ت	الفقرات	اوافق	غير متاكد	لا اوافق
١- تقويم الصحة الجسدية				
	أعاني من الاصابة بأحد الامراض التالية : السكر، الربو، ضغط الدم، الكولسترول			
	لدي زياده بالوزن بعد تعرضي للمرض.			
	عدم قدرتي على اداء الفعاليات اليومية مثل تناول الطعام والاستحمام.			
	أعاني من اضطرابات الجهاز الهضمي.			
	أعاني من اضطرابات الجهاز البولي.			
	أعاني من الآلام في الجسم.			
	أعاني من الشعور بالتعب.			
	أعاني من صعوبة بالنوم.			
٢- تقويم الصحة العقلية والنفسية				
	لدي صعوبة في التكيف مع الآخرين			
	أعاني من الكآبة.			
	لدي شعور بالحزن.			
	لدي شعور بالعجز			
	لدي شعور بالغضب.			
	أعاني من القلق والإحساس بالضعف والاستسلام للمرض			
	أعاني من الاضطراب العاطفي			
	لدي شعور باليأس.			
	أعاني من عدم الشعور بالأمان والخوف من المجهول			
	أعاني من الاضطرابات في الذاكرة.			
	أعاني من قلة التركيز			
٣- تقويم الصحة الاجتماعية				
	أعاني من التمييز الاجتماعي			
	أعاني من العزلة والاحساس بالوصمة			
	أعاني من صعوبة التفاعل والتواصل مع الآخرين			
	أعاني من اضطرابات في العلاقة الاجتماعية مع افراد العائلة			
	لدي القدرة على صناعة القرارات			
٤- تقويم الصحة السلوكية				
	أمارس التدخين (سكائر او شيشة).			
	أتناول الكحول.			
	لدي قله حركة (قله نشاط).			
	أتناول الادوية المخدرة			
	أمارس سلوكيات غذائية غير صحية مثل (تناول السكريات بكثرة او شرب المشروبات الغازية بكثرة)			

Appendix B

دائرة صحة ميسان
مركز ميسان لامراض وجراحة القلب
العدد/ ٧٦
التاريخ / العمارة

العدد: ش ع/ ١٠٤
التاريخ: ٢٤/ ١/ ٢٠٢١

NO:

Date:

مديرية صحة ميسان . دائرة صحة ميسان
مركز ميسان لامراض وجراحة القلب
الصادر
العدد/ ..... التاريخ

إلى/مركز إمراض وجراحة القلب

م/ تسهيل مهمة

تحية طيبة ...

يرجى تسهيل مهمة طلبة كليتنا المدرجة أسمائهم أدناه وذلك لإكمال متطلبات بحثهم الموسوم تحت عنوان(تقييم الحالة الصحية لمرضى أحشاء عضلة القلب في مركز ميسان لإمراض وجراحة القلب في مدينة العمارة) للعام الدراسي .

١-زينب خضير شيـــال .
٢-زينب سالم عبـــيد .
٣-هدى زامل عبـــيد .

.... مع التقدير...

أ.م.د رشيد رحيم حتيت
عميد الكلية
٢٠٢١/١/

باشر وليتاريخ ٢٤/١/٢٠٢١
وانتكو ليتاريخ ٦/٥/٢٠٢١
بعد اكمال متطلبات البحث
خماس زامل عبد
المعاون الاداري
٦/٥/٢٠٢١

الدكتور جاسم محمد الموسوي
اختصاصي جراحة القلب والاوعية الدموية

نسخة منه الى//

- مكتب السيد عميد كلية التمريض. مع التقدير .
- مكتب السيد معاون العميد للشؤون العلمية/... مع التقدير.
- شعبة الشؤون العلمية .
- الصادرة .

صفاء ١/٢٤

الخلاصة.

الخلفية: من المعروف أن أمراض القلب والأوعية الدموية هي الأسباب الرئيسية للأمراضية والوفيات في العالم اليوم وأن احتشاء عضلة القلب الحاد هو أحد هذه الاسباب التي تقلل من أنشطة الحياة اليومية للمرضى وكذلك تحد من ممارسة العمل وبالتالي تؤثر على حالتهم الصحية وجودة حياتهم.

الاهداف : أهداف الدراسة الحالية هو تقييم الحالة الصحية لمرضى احتشاء عضلة القلب في مركز ميسان لأمراض وجراحة القلب في مدينة العمارة. والتعرف على العلاقة بين مرضى احتشاء عضلة القلب وخصائصهم الاجتماعية والديموغرافية.

المنهجية: أُجريت الدراسة الوصفية في مركز ميسان لأمراض وجراحة القلب في مدينة العمارة . للفترة من 20 كانون الاول 2020 إلى 30 حزيران 2021. وتم اختيار عينة احتمالية "عشوائية" من (120) مريض كانوا مشخصين باحتشاء عضلة القلب. حيث تكونت ورقة الاستبيان من جزأين رئيسيين (الخصائص الاجتماعية والديموغرافية وتقييم الحالة الصحية). فجمعت البيانات من خلال استخدام الاستبيان المعتمد باللغة العربية، واستخدام اسلوب المقابلة النموذجية لكل مريض. تم تحديد ثبات الأداة من خلال استخدام ألفا كرونباخ فكان معامل الارتباط $r = 0.92$ ، فتم تحليل بيانات هذه الدراسة من خلال استخدام برنامج الحزمة الاحصائية للعلوم الاجتماعية ذي الإصدار 24 حيث اتبع الإحصاء الوصفي (التكرارات ، والنسب المئوية ، والمتوسط الحسابي ، ومتوسط الدرجة ، والانحرافات المعيارية) ، والإحصاء الاستدلالي (اختبار مربع كاي).

النتائج: أظهرت نتائج الدراسة أن غالبية المشاركين لديهم مستوى معتدل من التقييم للحالة الصحية فيما يتعلق بمرضى احتشاء عضلة القلب في عينة الدراسة (ن = 120 ؛ 77 (64.2٪) ، مع متوسط وانحراف معياري (2.13 ± 0.326) . وايضاُ أظهرت الدراسة الحالية تأثيراً واضحاً للمظاهر السريرية مثل (مدة المرض والأمراض المزمنة) على الحالة الصحية لمرضى احتشاء عضلة القلب.

الاستنتاجات: استنتجت الدراسة الحالية إلى أن التقييم العام للحالة الصحية لعينة مرضى احتشاء عضلة القلب في مركز ميسان لأمراض وجراحة القلب في مدينة العمارة كان متوسط المستوى. من الواضح أن احتشاء عضلة القلب يمكن أن يقلل من الحالة الصحية ونوعية الحياة ، مما يحد من فعالية الشخص في المشاركة المجتمعية.

التوصيات: أوصت الدراسة بتوفير برامج تثقيفية وبرامج توعية صحية لمرضى احتشاء عضلة القلب ، والتركيز على المتابعة والفحوصات الدورية للمرضى ، والتي من شأنها تحسين نوعية الحياة في المستقبل إلى مستوى جيد

وزارة التعليم العالي والبحث العلمي

جامعة ميسان

كلية التمريض

تقييم الحالة الصحية لمرضى احتشاء عضلة القلب في مركز ميسان لأمراض وجراحة القلب في مدينة العمارة

بحث تخرج تقدمت به :

زينب سالم عبيد

زينب خضير شيال

هدى زامل عبيد

الى كلية التمريض – جامعة ميسان

كجزء من متطلبات نيل شهادة البكالوريوس في علوم التمريض

بأشراف: **م .د. عقيل عزيز الرسيتم**

م .د. حميد ابولول جبجاب

محرم ١٤٤٣هـ آب ٢٠٢١م