University of Basrah
College of nursing

Risk Factor in Patient with Coronary Heart Disease at Basrah Hospitals

A research
Was submitted to the council of the college of nursing at the University of Basrah in partial fulfillment of the requirements for the degree of baccalaureate in nursing science

By
Ahmed Qasim Habtar
Yahia Sabah Faisal
Eman Abdel Hadi mokhtar

Fourth year 2021-2022
Supervised by Assist. Lecturer
Abdul Kareem Salman

يَا أَيُّهَا
الَّذِينَ آمَنُوا إِذَا قِيلَ لَكُمْ تَفَسَّحُوا فِي الْمَجَالِسِ فَافْسَحُوا يَفْسَحِ اللَّهُ
لَكُمْ ۖ
وَإِذَا قِيلَ انْشُزُوا فَانْشُزُوا يَرْفَعِ اللَّهُ الَّذِينَ آمَنُوا مِنْكُمْ وَالَّذِينَ أُوتُوا الْعِلْمَ دَرَجَاتٍ ۚ وَاللَّهُ بِمَا تَعْمَلُونَ خَبِيرٌ (١١)

صدق الله العلي العظيم

الاهداء

اهدي هذا البحث الى من ساندتني في صلاتها و دعائها الى من سهرت الليالي تنير دربي الى من تشاركني افراحي واساتي ال نبع الحنان و العطف الى اجمل ابتسامة في حياتي. الى اروع امرأة في الوجود : امي الغالية .

الى من علمني ان الدنيا كفاح وسلاحها العلم والمعرفة الى الذي لم يبخل علي باي شيء الى من سعى لأجل راحتي ونجاحي الى ابي العزيز .

الى الذي ظفرت بهم هدية من الاقدار اخوتي الاحباء واخواتي العزيزات و اقدم اهداء خاص الى كل من علمني وارشدني الى طريق العلم والنجاح والى كل طالب علم يسعى لكسب المعرفة والى كل الطلبة المشاركين في البحث.

الى كل هؤلاء نهدي بحثنا

Supervisor's support

I certify that this project of research

" ***Risk Factors in Patient with Coronary Heart Disease at Basrah Hospitals*** "

was prepared under my

supervision at the College of Nursing, University of Basrah

Dr. Abdul Kareem Salman of Basrah Nursing of Collage
19/ 4 / 2022

Acknowledgement

We would like to express our thanks to our professors and experts at the College of Nursing, University of Basra for allowing us to conduct the research, and we would like to express our sincere thanks with our deepest respect to Dr. (Abdul Kareem Salman) for his constructive work and his outstanding supervision. Thank you to the person who trusts us and participates in this work for his efforts and valuable time.

Abstract

Background: Coronary heart disease (CHD) is the most common cause of death worldwide ,The prevalence of CHD is more in males than females Incidence of CHD is rising in population wilh poor socioeconomic status, Thus, the term 'Coronary heart disease' refers to heart problems caused by narrowed heart arteries. When arteries are narrowed, less blood and oxygen reaches the heart muscle. This is also called Ischemic heart disease and coronary heart disease. It can ultimately lead to heart attack.

Objective: To assess knowledge patients about risk factors of coronary heart disease.

Knowing the impact of psychological and social status on coronary heart disease

Methodology: A cross-sectional study design was carried out in Basrah hospital involving (300) patients (male and female).started from 20 February 2021 up to 20 April 2022, A Closed-end questions questionnaire was used for the purpose of data collection. Analysis was made by using Excel, data was expressed in (frequency, percentage and mean of score).

Results: the most participants of questionnaire are male (71%).36% of them age 41-60year.59% have medium income and 39.7 have BMI29.9-25 and that all of the participants mean of score were significant except question 7 was in significant and the total mean of score was 1.5 (significant).

Conclusions: The percentage of BMI ranged 29.9-25 was 39.7 %.Male were (71%). and 36% of them age 41-60year.Total mean of score was 1.5 (significant).

List of Tables

Chapter one

Introduction

Introduction

1.1 Introduction

Coronary artery disease (CAD, also called coronary heart disease, or CHD) is caused by the narrowing of the large blood vessels that supply the heart with oxygen. These are called coronary arteries. Arteries that have become extremely narrow can cause shortness of breath and chest pain during physical activity. If a coronary artery suddenly becomes completely blocked, it can result in a heart attack. ***Zwisler A-D, Rees K, Martin N et al.(2016)***

CAD can also lead to other health problems like heart failure or heart rhythm problems. Various treatments can be used to reduce the symptoms and the risk of complications. ***Bundesärztekammer, et al.February 19, 2016.***

CAD is caused by arteriosclerosis (hardening of the blood vessels). Arteriosclerosis develops from minor inflammations in the walls of blood vessels. Cells, fats and other substances stick to the walls there and form deposits. These are called plaques. ***Anderson L, Thompson DR, Oldridge N,(2016)***

When the blood flow to the heart muscle is completely blocked, the heart muscle cells die, which is termed a heart attack or myocardial infarction (MI). Most people with early (less than 50 percent narrowing) CHD do not experience symptoms or limitation of blood flow ***Abdel-Latif, and W. D. Weaver.(2016).***

However, as the atherosclerosis progresses, especially if left untreated CHD is the most common cause of death worldwide.The prevalence of CHD is more in males than females.Incidence of CHD is rising in population poor socioeconomic e.g. (Pakistan ,India, and Bangladesh) ***HIMAYAT ULLAH,oct,4,(2021).***

1.2 Importance of the study

Improving acute coronary syndrome care and better secondary prevention can significantly reduce CHD mortality in LLMICs ***James S, et al.(2019).***

we initially focus on gaps in the quality of acute CHD management and secondary prevention and then highlight the importance of primary prevention in LLMICs, especially among the more vulnerable individuals of lower SES. We also highlight a few strategies to overcome these challenges**.** ***Gaziano TA, Prabhakaran D,(2019***)

1.3 Statement of the problem

Knowledge of patients about the risk factors for ischemic heart disease in basrah hospitals.

1.4 Objective of the study

1-To assess knowledge patients about risk factors of ischemic heart disease.

2-Knowing the impact of psychological and social status on ischemic heart disease.

Chapter two

Literature review

Literature review

2.1 Coronary heart disease:

Coronary heart disease, also called Ischemic heart disease (IHD) or coronary artery disease, is the term given to heart problems caused by narrowed heart (coronary) arteries that supply blood to the heart muscle. Although the narrowing can be caused by a blood clot or by constriction of the blood vessel, most often it is caused by buildup of plaque, called atherosclerosis ***(W. S. Weintraub. 2017).***

When the blood flow to the heart muscle is completely blocked, the heart muscle cells die, which is termed a heart attack or myocardial infarction (MI). Most people with early (less than 50 percent narrowing) CHD do not experience symptoms or limitation of blood flow***[Abdel-Latif, and W. D. Weaver. 2016].***

However, as the atherosclerosis progresses, especially if left untreated, symptoms may occur. They are inhibitors in coronary artery disease and preserved left ventricular systolic function: A systematic review and meta-analysis of randomized controlled trials. *Journal of the American College of Cardiology* most likely to occur during exercise or emotional stress, when the demand for the oxygen carried by the blood increases***[A. K. Jacobs. 2014].***

2.2 Epidemiology

On the basis of data from the National Health and Nutrition Examination Survey (NHANES) for the period 2003 to 2006, an estimated 17.6 million Americans age 20 or older have CHD, with an overall prevalence of 7.9 percent (9.1 percent in men and 7 percent in women). The overall prevalence of MI is 3.6 percent (4.7 percent in men and 2.6 percent in women). The estimated annual incidence of MI is 935,000, which includes 610,000 new and 325,000 recurrent infarctions. The overall prevalence of angina pectoris is 4.6 percent, with age-adjusted prevalence higher in women than men. CHD accounts for more than half of all cardiovascular events in men and women under age 75. The lifetime risk of developing CHD after age 40 is 49 percent for men and 32 percent for women ***(Lloyd-Jones et al., 2010)***

CHD is the leading cause of death in both men and women. It caused one of every six U.S. deaths in 2006; CHD mortality was 425,425, and MI mortality was 141,462. Approximately every 25 seconds, an American will experience a coronary event, and approximately every

minute a death will be attributed to a coronary event. Approximately every 34 seconds, an American will have an MI and 15 percent will die of it. In addition, in 2006, 1,115,000 inpatient diagnostic cardiac catheterizations were performed as well as 661,000 inpatient percutaneous coronary interventions (PCIs) and 253,000 coronary artery bypass surgery (CABG) procedures***(Lloyd-Jones et al., 2010).***

2.3 Pathophysiology

The imbalance between myocardial oxygen supply andupon the agent used. Nitrates alter both myocardial oxygen supply and demand, while /?-blockers decrease myocardial oxygen demand. Calcium channel blockers reduce after- load and myocardial contractility and, thus, lower oxygen demand, while the coronary artery relaxation that occurs in response to their use acts to increase supply. The use of combination therapy, is considered by many to be the most rational approach to the treatment of myocardial ischaemia, in that it allows maximal reduction in demand and increase in supply***.(yens pot J 2016)***

channel blockers, nitrates, combination therapy.factor that causes an increase in myocardial oxygen demand or a reduction in myocardial oxygen supply can provoke ischaemia. Myocardial oxygen requirements rise with increases in heart rate, contractility or left ventricular wall stress. Myocardial oxygen supply is determined by coronary blood flow and myocardial oxygen extraction, with the latter normally being near maximal at rest. ***(Ganz P,2014)***

For some time, residual coronary flow reserve was thought to remain constant in the presence of a fixed atherosclerotic obstruction. However, Maseri proposed that residual coronary flow reserve is not fixed, butrather is subject to variations throughout the day in 12response to dynamic changes in vasomotor tone '. Although residual coronary flow reserve still has an upper limit, this value fluctuates in response to changes in resistance at the site of flow-limiting stenoses. Ischaemic episodes continue to occur at high levels of demand (such as with physical exertion) when that demand exceeds the maximal residual coronary flow reserve, but ischaemia may also occur at lower levels of energy consumption due to a transient reduction in flow reserve. ***(Selwyn AP, 2012)***

2.4 Risk factors

2.4.1Age

Your risk of cardiovascular disease(CVD) rises as you become older. Men's CVD occurrence rises after 45 years, whereas women's risk rises after 55 years.Even when there is no disease, aging is connected to cardiovascular disease as your heart acts less efficiently as you age, your heart muscle weakens, and your heart's pumping chambers may become stiff ***(Varveri, A ,2019).***

2.4.2 Gender

In comparison to women, men are at a higher risk. Due to a decline in estrogen levels, this percentage drops after women reach menopause, increasing the risk for women until it matches that of males. After the age of 65, the risk for heart disease is about the same between the sexes when other risk factors are similar ***(Brown, J. C,2020).***

2.4.3 Family history

Your particular risk is strongly influenced by your family's history of cardiovascular disease. A positive family history of heart disease in your father or brother diagnosed before the age of 55 and your mother or sister diagnosed before the age of 65 is generally associated with a twofold increase in the risk of CVD ***(Timmis A, 2014).***

2.4.4 Socio-economic status

Evidences suggested that people from lower/middle social classes were in greater CHD risk than higher social classes***(Lancet 2014).***

2.4.5 smoker

You are probably well-aware that smoking leads to asthma, emphysema and lung cancer but did you know it is also a contributing factor to heart disease? When you light up a cigarette or cigar, you are potentially causing a buildup of fatty substances in your arteries, known

as atherosclerosis. Yet another reason to kick your smoking habit for good. ***Shi W, et al.(2015)***

"If you want to stop smoking, I recommend making a list of the times in the day when you must have a cigarette, such as with your morning coffee, while meeting with friends or at mealtimes," he says. "Then eliminate them one by one over time. Smoking 10 cigarettes a day is better than smoking 20. Smoking zero is best, but that is hard to achieve right away. If you relapse, try again. Use nicotine replacement patches or gum to give your body the nicotine it craves. Do not valp because we don't know what is in vaping liquids. ***Joshi R, et al.(2012)***

2.4.6 Hyperlipidemia

As increased triglycerides have been linked to coronary artery disease, hyperlipidemia is regarded as the second most frequent risk factor for ischemic heart disease.It's recommended to use statin for the primary prevention of cardiovascular disease between 40 to 75 years of age.The following lipid and lipoprotein abnormalities are associated with increased IHD risk ***(Brown, J. C,2020).***

2.4.7 Diabetes

Increased blood glucose levels (sugar levels) have been associated with a greater risk of an infarction. It is important for individuals to maintain good control over their blood sugar, either with tablets or insulin. Losing weight, eating an appropriate diet and exercising regularly can all be of great help when it comes to controlling sugar levels. ***Gersh BJ, et al.(2010)***

2.4.8 Obesity

Being overweight is increasingly common in today's society and worsens the other risk factors. Even losing just a little weight can be very beneficial for the cardiovascular system. ***Gaziano TA, et al.(2017)***

2.4.9 Hypertension

damages artery walls and can accelerate the atherosclerosis process. Quitting smoking, losing weight and exercising are a few ways of reducing blood pressure which also have a very positive influence on the state of your arteries. ***Sadeghi M, et al.(2017)***

2.4.10 Psychosocial factors

Psychosocial risk factors like low socio-economic status, lack of social support and social isolation, chronic work or family stress, as well as negative emotions, e. g. depression and hostility, contribute significantly to the development and adverse outcome of coronary heart disease (CHD). **Geiser F, et al. (2012).**

2.5 clinical manifestation

2.5.1 chest pain

The pain that usually characterizes Ischemic Heart Disease is described as tightness in the chest which can occasionally radiate to the base of the neck, the jaw, arms (normally the left arm) or back. It is sometimes accompanied by shortness of breath, dizziness, cold sweats, nausea and vomiting, palpitations or even loss of consciousness**(Manel Sabaté ,2018).**

2.5.2 Shortness of breath (dyspnea).

The heart becomes weaker and can no longer pump blood towards the rest of the body. Therefore blood stagnates in the lungs, which fill with fluid, and it becomes harder to breathe. This is one of the most significant complications because it indicates that the infarction (or angina) is severe ***(Manel Sabaté ,2018).***

2.5.3 Palpitations.

Patients notice a strong, or offbeat, heartbeat in their chest which could be secondary to an arrhythmia. There are many types of palpitation of varying severity, but they all tend to produce a rapid pulse and a fluttering or thumping feeling in the chest***(Marta Farrero,2018)***

2.5.4 Sweating

nausea and vomiting. These symptoms may all appear together or individually. In reality they are caused by the body's response, specifically that of the nervous system, to the heart muscle ischemia which represents a serious injury***(Manel Sabaté ,2018)***.

2.5.5 Loss of consciousness.

In the context of an infarction a loss of consciousness is due to problems with the heart's electrical conduction or the presence of severe arrhythmias, because it loses all capacity to pump blood (cardiac arrest) ***(Marta Farrero ,2018).***

2.6 Diagnosis

2.6.1 Electrocardiograph

tests (ECG): This test records the electrical activity of the heart. Can detect heart attack, ischemia and heart rhythm issues. ***Sadeghi M, et al.(2017)***

2.6.2 Exercise stress tests

This is a treadmill test to determine how well your heart functions when it's working the hardest. Can detect angina and coronary blockages. ***Kheradmand M, et al.(2019)***

2.6.3 Echocardiogram:

This test uses sound waves to see how well the structures of your heart are working and the overall function of your heart. ***Yang Z-J, Liu J, Ge J-P, et al.(2011)***

2.6.4 Blood tests:

Many blood tests are ordered for factors that affect arteries, such as triglycerides, cholesterol, lipoprotein, C-reactive protein, glucose, HbA1c (a measure of diabetes control) and other tests. ***Poustchi H, Eghtesad S, et al.(2017)***

2.6.5 Cardiac catheterization:

This test involves inserting small tubes into the blood vessels of the heart to evaluate heart function including the presence of coronary artery disease. ***Eghtesad S, Mohammadi Z, et al.(2017)***

2.6.6 Computed tomography angiogram:

Uses CT and contrast dye to view 3D pictures of the moving heart and detect blockages in the coronary arteries. ***Klein S, Allison DB, et al.(2012)***

2.7 Treatment

The main goals of pharmacological treatment of ischemic heart disease are reducing the number of nagging symptoms and preventing cardiovascular events ***(Paciorek P et al.2018)***.

The main groups of drugs used are: short and long-acting nitrates, β-blockers, calcium chan- nel antagonists, lipid-lowering drugs, anticoagulants, angiotensin-converting-enzyme inhibitors (ACE inhibi- tors). General conservative treatment includes the in- clusion of at least one antianginal/anti-ischemic drug and drugs used to prevent cardiovascular events. At this stage of treatment, it is important to educate patients about the disease entity, risk factors and treatment. In fighting with angina, short-acting ni- trates are recommended. First-line therapy includes β-blockers and/or calcium channel antagonists. Depending on the heart rate and arterial pressure, long-acting nitrates are added ***(Kubica J,et al2017)***.

The prevention of cardiovascular events is based on all patients on low- dose acetylsalicylic acid (ASA). In the event of intolerance of ASA, clopidogrel is recommended. In addition, statins are recommended for all of patients. In the case of heart failure, hypertension or diabetes, ACE inhibi- tors are used. This general strategy can be modified depending on comorbidities, patient preferences and costs of treatment .eryday life. Patients should be instructed to do aerobic exercise. Exercises reduce unnecessary kilograms, act against blood clotting, reduce blood glucose levels and improve well-being. Training sessions at least 3 times a week for 30 minutes is the minimum recommended by the Europe- an Society of Cardiology .In patients with ischemic heart disease, a comprehensive risk reduction including influenza vaccination is recommended .To achieve maximum control over the disease should be paid attention on the occurrence of stress, depression and anxiety in patients. This directly affects the acceptance of the disease and adjust to treatment recommendations ***(Herrmann-Lingen C et al 2018).***

2.8 Prevention

CHD prevention involves primordial, primary, and secondary prevention ***[Gupta R, Wood D2019].***

Primordial prevention is defined as preventing the onset of the risk factors by addressing the underlying political, social, and economic determinants at the population level **[Daniels SR,et al.2011].**

Primary prevention involves the control of major cardiovascular risk factors (tobacco use, high blood pressure (BP), cholesterol, diabetes, etc.) among individuals identified through systematic or opportunistic screening. Modeling studies in Europe and the USA have reported that 50–60% of the decline in CHD mortality is attributable to prevention strategies at both population and individual levels **[Croft JB, et al2017].**

High quality acute coronary disease management and secondary prevention for those who have survived the initial coronary event are important and responsible for 30–40% of the IHD mortality decline in HICs .However, prevention efforts have shown variable results in different countries. In Finland, the effects of primary prevention seem to dominate, yet in several other MICs and upper-middle-income countries in Europe, Americas and Asia, the decline is due to improved clinical management and secondary prevention, as reported in MONICA cohorts ***[Vanuzzo D, Hobbs M, et al.2014]***.

We believe that improving acute coronary syndrome care and better secondary prevention can significantly reduce IHD mortality in LLMICs .Herein, we initially focus on gaps in the quality of acute IHD management and secondary prevention and then highlight the importance of primary prevention in LLMICs, especially among the more vulnerable individuals of lower SES. We also highlight a few strategies to overcome these challenges***[James S.2019]***

Chapter three

Methodology

Methodology

3.1 Design of the study

A descriptive cross-sectional study design was carried out in Basrah hospital involving (300) patients (male and female).started from 20 February 2022 up to 20 April 2022, in order to study the To assessment knowledge patients about risk factors of ischemic heart disease in basrah hospitals.

Knowing the impact of psychological and social status on ischemic heart disease in basrah hospitals.

3.2 Setting of the study

The present study was conducted at Basra-hospital,

Involving cardiopulmonary resuscitation

3.3 The sample of the study

A random sample which consisted (300) patients

3.4 Study's instrument

A closed-end question questionnaire was used for the purpose of data collection. The questionnaire contains tow part, the first part consists of 4 items related to socio-demographic Characteristics of the patients and include: age, gender, social status, body mass index.

The second part of the questionnaire consists of risk factors related to coronary heart disease, which consists of 8 questions.

3.5 Statistical analysis

Analysis was made by using Excel

3.6 Descriptive

1- Percentage (%)

2- frequency

3- Mean of scores.

Chapter four

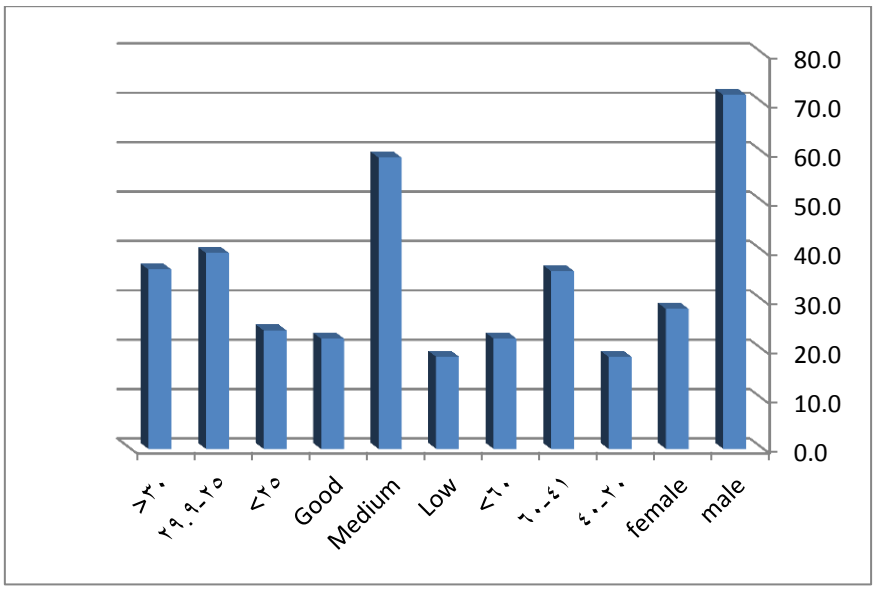
The Result

Chapter four The Result:

4-1 Table(1) The frequency and percentage of demographic

Table 1		Frequent	Percentage
Gender	Male	215	71.7
	Female	85	28.3
Age	20-40	56	18.7
	41-60	108	36.0
	>60	67	22.3
Social state	Low	56	18.7
	Medium	177	59.0
	Good	67	22.3
BMI	<25	72	24.0
	25-29.9	119	39.7
	>30	109	36.3

The table showed that the most participants of questionnaire are male (71%).36% of them age 41-60year.59% have medium income and 39.7 have BMI29.9-25



4-2 Table (2) Frequencies , percentage and mean of score for scientific information.

	Table 2	Yes		No			
	Questions	**F**	**%**	**F**	**%**	**MS**	**S**
1	**Were you smoker before getting the disease?**	175	58.3	125	41.7	1.6	**S**
2	**Did you suffer from high blood pressure before getting the disease?**	202	67.3	98	32.7	1.7	**S**
3	**Did you suffer from dyslipidemia before getting the disease?**	189	63.0	111	37.0	1.6	**S**
4	**Did you have diabetes before getting the disease?**	149	49.7	151	50.3	1.5	**S**
5	**Do you suffer from psychological or social problems?**	162	54.0	138	46.0	1.5	**S**
6	**Do you suffer from physical inactivity and lack of movement?**	146	48.7	157	52.3	1.5	**S**
7	**Do you have a family history of this disease?**	144	48.0	156	52.0	1.5	**S**
8	**Were you drinking alcohol before getting the disease?**	37	12.3	263	87.7	1.1	**NS**
	Total					1.5	**S**

The table showed that all of the participants mean of score were significant except question 7 was in significant and the total mean of score was 1.5 (significant).

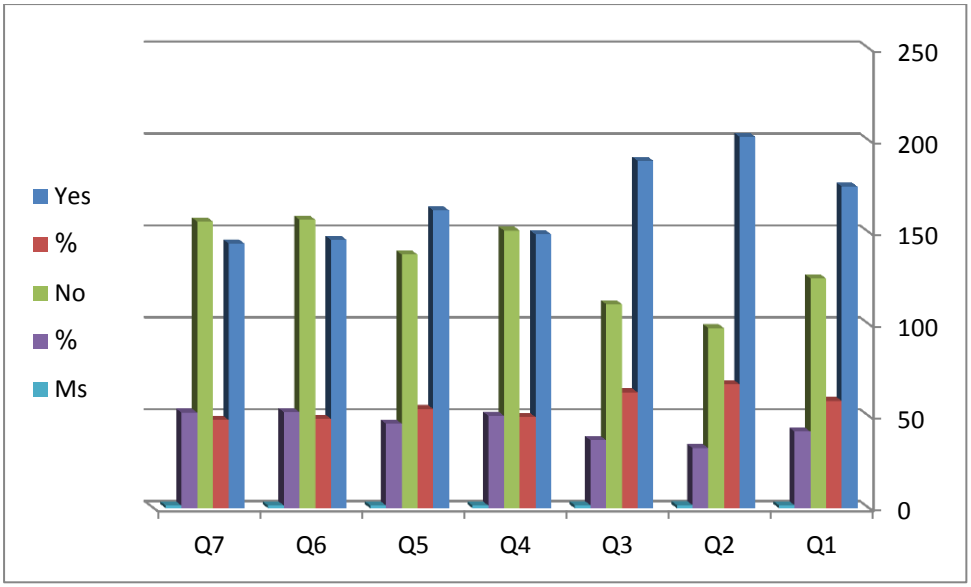


Figure (2) Frequencies , percentage and mean of score for scientific information

Chapter five
Discussion

Chapter five Discussion:

Ischemic heart disease still represents a large burden on individuals and health care resources worldwide. By conventions, it is equated with atherosclerotic plaque due to flow-limiting obstruction in large-medium sized coronary arteries. However, clinical, angiographic and atopic findings suggest a multifaceted pathophysiology for ischemic heart disease and just some cases are caused by severe or complicated atherosclerotic plaques. **(Paolo et al.,2020).**

The table (1) showed that all of the participants mean of score were significant except question 7 was in significant and the total mean of score was 1.5 (significant). And table (2)Regarding risks factors information were mean of score were significant except question 7 was in significant and the total mean of score was 1.5 (significant).***Massimo et al., (2018)***

concluded that stress included specific sections related to stress-induced myocardial ischemia measurements and stress cardiomyopathy. The complex network of reciprocal interconnections between the heart and the main biological systems we have presented in this paper provides a new vision of cardiovascular science based on psychoneurotic endocrine immunology**. *Puja et al., (2015)***

found that risk factors in women such as adverse pregnancy outcomes, systemic autoimmune disorders, obstructive sleep apnea, and radiation-induced heart disease; psychosocial factors such as mental stress, depression, anxiety, low socioeconomic status, and work and marital stress play an important role in IHD in women. A variety of studies has proved that cigarette smoking induces oxidative stress, vascular inflammation, platelet coagulation, vascular dysfunction and impairs serum lipid pro-file in both current and chronic smokers, active

and passive smokers and results in detrimental effects on the cardiovascular system. The aim of this review is to depict the physical and biochemical properties of cigarette smoke and, furthermore, elucidate the main pathophysiological mechanisms of cigarette-induced atherosclerosis and overview the new therapeutic approaches for smoking cessation and augmentation of cardiovascular health. (**Gerasimos et al.,2014).**

Chapter six

Conclusion and Recommendati

Chapter six Conclusion and Recommendation:

6-1 Conclusions:

The results concluded the followings:

1- The percentage of BMI ranged 29.9-25 was 39.7 %.

2- Male were (71%). and 36% of them age 41-60year.

3- Total mean of score was 1.5 (significant).

6-2 Recommendations

1-Primary prevention through Education programs that deal with risk factor of IHD like HT, DM, obesity and hyperlipidemia.

□□□Early screening and early treatment for IHD.

□□□Educate people about the clinical features of IHD especially for young adults.

□□□Further studies for the same subject should try to overcome the confounding

References

1- *Zwisler A-D, Rees K, Martin N et al.(2016)*
2- *Bundesärztekammer, et al.February 19, 2016.*
3- *Anderson L, Thompson DR, Oldridge N,(2016)*
4- *Abdel-Latif, and W. D. Weaver.(2016).*
5- *James S, et al.(2019).*
6- **Al-Mallah, M. H., I. M. Tleyjeh, A. A. Abdel-Latif2016.**
7- **Mendis S, Puska P, Norrving B;2015**
8- **Lloyd-Jones, D., R. J. Adams, T. M. Brown, 2010**
9- **Ganz 2012**
10- **Bisciglia, A., Pasceri, V., Irini, D., Varveri, (2019).**
11- **Brown, J. C., Gerhardt, T. E., & Kwon, E. (2020**
12- **Rapsomaniki E, Timmis A, George J, et al. 2014**
13- **Yusuf S, Hawken S, Ounpuu S, et al. 2014**
14- **Hennekens CH 2016**
15- **Dallas, 2011**
16- **Nyboe J, Jensen G(2017)**
17- **Willett WC(2013)**
18- **Shi W, et al.(2015)**
19- **Joshi R, et al.(2012)**
20- **Gersh BJ, et al.(2010)**
21- **Gaziano TA, et al.(2017)**
22- **Sadeghi M, et al.(2017)**
23- **Kheradmand M, et al.(2019)**
24- **Yang Z-J, Liu J, Ge J-P, et al.(2011)**
25- **Poustchi H, Eghtesad S, et al.(2017)**
26- **Kawachi I, Colditz GA(2016)**
27- **van Berkel TF, Boersma H, Roos-Hesselink (2014)**
28- **LaCroix AZ, Lang J, Scherr P et al(2014)**
29- **Hermanson B, Omenn GS, Kronmal RA(2016)**
30- **Cullen P, Schulte H, Assmann G. (2015)**
31- **Eghtesad S, Mohammadi Z, et al.(2017)**
32- **Klein S, Allison DB, et al.(2012)**
33- **Garnett S, Baur L, et al.(2018)**
34- **Manel Sabaté Tenas 20 February 2018**
35- **Marta Farrero Torres 20 February 2018**
36- **Gupta R, Wood D. 2019**
37- **Weintraub WS, Daniels SR, Burde LE, et al. 2011**
38- **Unal B, Critchley JA, Capewell S. 2014**

39- Ford ES, Ajani UA, Croft JB, et al. 2017
40- Tunstall-Pedoe H, Vanuzzo et al2010
41- Ridker PM, et al.(2014)
42- Beshara A, Cohen E, et al.(2016)
43- *Prabhakaran D,(2019*)
44- James S. Acute coronary syndromes. 2019
45- Paolo Severino, Andrea D'Amato (2019)

Appendices A

Risk factor in patient with coronary heart disease at Basra hospitals

1-Gander: ☐ **- male**

☐ **- Female**

2-Age: ☐ **-20-40**

☐ **- 41-60**

☐ **- >60**

3-Social status: ☐ **- degraded**

☐ **-medium**

☐ **- good**

5-Body mass: ☐ **- length**

☐ **- weight**

Risk factors for patients with coronary heart disease :

1-Were you smoker before getting the disease?

- ☐ **Yes**
- ☐ **No**

2-Did you suffer from high blood pressure before getting the disease?

- ☐ **Yes**
- ☐ **No**

3- Did you suffer from dyslipidemia before getting the disease?

- ☐ **Yes**
- ☐ **No**

4- Did you have diabetes before getting the disease?

- ☐ **Yes**
- ☐ **No**

5- Do you suffer from psychological or social problems?

- ☐ **Yes**
- ☐ **No**

6- Do you suffer from physical inactivity and lack of movement?

- ☐ **Yes**
- ☐ **No**

7- Do you have a family history of this disease?

- ☐ **Yes**
- ☐ **No**

8- Were you drinking alcohol before getting the disease?

- ☐ **Yes**
- ☐ **No**

الخصائص الاجتماعية والديموغرافية للمرضى :

١- الجنس : ذكر ☐ - انثى ☐

٢- العمر : 20-40 ☐ - 41-60 ☐ > 60 ☐

٣- الحالة الاجتماعية : متردية ☐ - متوسطة ☐ - جيدة ☐

٤- كتلة الجسم : الوزن ☐ الطول ☐

عوامل الخطر للمرضى الذين يعانون من مرض تصلب شرايين القلب التاجية :

ت	العوامل	نعم	لا
١	هل كنت تدخن قبل الاصابة بالمرض ؟		
٢	هل كنت تعاني من ارتفاع ضغط الدم قبل الاصابة بالمرض ؟		
٣	هل كنت تعاني من ارتفاع نسبة الدهون قبل الاصابة بالمرض؟		
٤	هل كنت مصاب بداء السكري قبل الاصابة بالمرض؟		
٥	هل كنت تعاني من مشاكل نفسية او اجتماعية ؟		
٦	هل كنت تعاني من الخمول الجسدي وقلة الحركة ؟		
٧	هل لديك تاريخ عائلي في هذا المرض ؟		
٨	هل كنت تشرب الكحول قبل الاصابة بالمرض ؟		

List of experts

قائمة الخبراء				
الاسم	اللقب العلمي	الشهاده	التخصص	مكان العمل
د .سجاد سالم عيسى	استاذ	دكتوراه	طب صحة مجتمع	كلية التمريض
د.سندس باقر داود	استاذ مساعد	دكتوراه	فلسفة التمريض	كليه التمريض
د.فراس عبد القادر جاسم	استاذ	دكتوراه	طب اسرة	كليه التمريض
د.واثق فرعون	مدرس	دكتوراه	فسلجة	كلية التمريض
م.م خديجة محمد سالم	مدرس مساعد	ماجستير	تمريض بالغين	كلية التمريض

الخلاصة

الخلفية : مرض القلب الاقفاري هو السبب الاكثر شيوعا للوفاة في جميع انحاء العالم وانتشار مرض القلب الاقفاري في الذكور اكثر من الاناث .مشاكل القلب الناتجة عن تضيق شرايين القلب التاجية عندما تضيق الشرايين يقل وصول الدم والاكسجين الى عضلة القلب وهذا ما يسمى ايضا بمرض الشريان التاجي ومرض القلب التاجي يمكن ان يؤدي في النهاية الى نوبة قلبية.

الاهداف : تقييم معرفة المرضى حول عوامل الخطر لمرض نقص تروية القلب.لإيجاد علاقة بين البيانات الديموغرافية والمعرفة.معرفة تأثير الحالة النفسية والاجتماعية على أمراض القلب الإقفارية

المنهجية: تم تنفيذ تصميم دراسة مقطعية في مستشفى البصرة شملت (٣٠٠) مريض (ذكور وإناث) ، وبدأت من ٢٠ فبراير ٢٠٢١ حتى ٢٠ أبريل ٢٠٢٢ ، تم استخدام استبيان اسئلة مغلق لغرض جمع البيانات . تم اجراء التحليل باستخدام برنامج اكسل ، وتم التعبير عن البيانات في (التكرار والنسبة المئوية ومتوسط الدرجة)

النتائج: معظم المشاركين في الاستبيان هم من الذكور (٧١٪) ٣٦٪ منهم تتراوح أعمارهم بين ٤١-٦٠ سنة ٥٩٪ لديهم دخل متوسط و ٣٩.٧ لديهم مؤشر كتلة الجسم ٢٩.٩-٢٥ وأن جميع المشاركين متوسطات درجاتهم كانت معنوية باستثناء السؤال ٧ كان معنويًا وكان المتوسط الكلي للدرجات ١.٥ (معنويًا).

الاستنتاجات: كانت النسبة المئوية لمؤشر كتلة الجسم التي تراوحت بين ٢٩.٩-٢٥ ٣٩.٧٪ ، وبلغت نسبة الذكور (٧١٪). و ٣٦٪ منهم تتراوح أعمارهم بين ٤١-٦٠ سنة ، ومتوسط الدرجة الكلية ١.٥ (معنوي).

جامعة البصرة

كلية التمريض

(عوامل الخطر لمريض تصلب الشرايين التاجية في مستشفيات البصرة)

بحث

تم تقديمه إلى مجلس كلية التمريض في جامعة البصرة في استيفاء جزئي لمتطلبات
درجة البكالوريا في علوم التمريض

بواسطة الطلبة :

احمد قاسم حبتر

يحيى صباح فيصل

ايمان عبد الهادي مختار

إشراف

د. عبد الكريم سلمان

2021-2022