

First frequency distributions of patients according to socio-demographic, history of present illness, past history and general physical examination, lifestyle assessment, were tabulated.

RESULTS

The analysis showed that fruit and vegetable consumption was slightly higher than expected, better-educated patients were more likely to have better knowledge regarding both blood pressure and cholesterol and knowledge level was generally higher after intervention for blood pressure than cholesterol, level of education was associated with risk factors after adjusting for age, sex. The college graduates were able to state their own blood pressure and to know that 140/90 mmHg or less is a good blood pressure thus were more than three times knowledge able than patients who had not completed high school; college graduates also had higher odds of engaging in regular aerobic exercise and lower odds of being obese; educational level also affected the body mass index(BMI), the interaction between sex and education was significant ($p < 0.01$); those with BMI 25.9 kgr/m² in lifestyle intervention group reduced the intake of saturated fat, sugar and high diet cholesterol ($p < 0.001$), increased their exercise level after education ($p=0.01$) and stopped smoking ($p < 0.05$) when compared with control group; 95% confidence interval was significant.

DISCUSSION

The main finding of this study was that education and modification of lifestyle of patients with intervention package were independently associated with behavioral risk factors for cardio vascular disease and reducing of blood pressure; smoking; lack of regular exercise, and obesity, as well as knowledge about blood pressure, were significant. In order to study the effect of risk factor modification by means of NIL pharmacological interventions in patients suffering from CHD, we scrutinized every risk factor separately. Each factor was amenable to modification through interventions, aimed at behavior change. Behavior oriented interventions, incorporating cognitive and behavioral factor smoking cessation techniques, showed positive results in reducing smoking rates in MI patients¹⁵. Elevated serum cholesterol concentrations were reduced by intensive dietary modification. Thus, major changes on dietary habits can be achieved in CHD patients, and this may even lead to stabilization or regression of coronary atherosclerosis. Several studies indicated that physical exercise may prevent progression of atherosclerosis as well. Secondary prevention programs aimed at increasing physical exercise can bring about reduced cardiovascular mortality and morbidity, although unambiguous evidence concerning these effects is still lacking. Thus, to be maximally effective, risk management should focus on selection of patients most likely to benefit from particular program, or even better, patients should be referred to the treatment that is most appropriate for their needs. This is in accordance with recent general guidelines for cardiac rehabilitation as formulated by WHO and later Great Britain, the Netherlands and other European

countries; these emphasize determination of the patients needs and individual sub goals for rehabilitation in theory, the most suitable type of cardiac rehabilitation, should be chosen, but in actual practice the needs of individual patients are still barely taken into account. To optimize the effects of cardiac rehabilitation, every patients should be screened to determine which risk factors contribute to his or her condition, after which the most suitable cardiac rehabilitation program should be applied. Very likely this approach will improve the patients motivation, which could have a favorable influence on the effects of the intervention. It was shown that exceptionally motivated patients make comprehensive lifestyle changes that lead to improved cardiovascular status. To reach the majority of patients better applicable, although effective behavioral interventions should be developed. In particular the motivation to sustain favorable effects, should be enforced, with more intensive changes; whatever the patient decides, the cardiologist should support this decision and explain the relative risks, benefits, costs, and side effect of each secondary prevention approach, be it invasive or noninvasive, pharmacological, or non pharmacological.

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