
Secondary prevention in coronary artery disease: the need for intensified efforts

INVITER KOMMENTAR

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To improve goal achievement in secondary prevention of coronary artery disease, new approaches are needed, with more use of digital monitoring and a personalised approach.

Using data from the Norwegian Myocardial Infarction Registry (NORMI), Jortveit et al. studied goal achievement for secondary prevention in patients diagnosed with coronary artery disease [\(1\)](#). Over a ten-year period, they found that overall goal achievement was low, with minimal improvement over the period. The authors conclude that intensified efforts are needed in both primary care and the specialist health service.

The findings are both disappointing and surprising. Surprising, because the annual incidence of myocardial infarction decreased by 3–4 % over the study period [\(2\)](#). The authors suggest that primary prevention has been more successful than secondary prevention, an assumption supported by the observation that 28 % of patients experiencing a myocardial infarction in 2024 had a prior event [\(3\)](#).

Only 1.8 % of the study population achieved all six defined treatment goals. Dietary and physical activity recommendations were not assessed, as NORMI lacks data on these measures, and adherence to such advice may also be challenging [\(4\)](#).

Are the treatment goals in current guidelines unrealistic? Opinions may differ, but there is robust scientific evidence underpinning the recommendations given [\(5\)](#). Goal achievement was high for the prescription of secondary preventive medications, but

low for lipid and blood pressure targets. These findings suggest that follow-up has been inadequate and reinforce the authors' conclusion that improvements are needed.

The study included patients up to 85 years of age. LDL-cholesterol targets were tightened during the study period, from 2.5 mmol/L to 1.4 mmol/L. At the lowest level, only 9.3 % of patients achieved the treatment goals. European Society of Cardiology (ESC) guidelines apply across all age groups without differentiation. The authors emphasise that, for the oldest patients, treatment goals must be adapted to the individual's overall situation – a point that cannot be overstated. Guidelines are just guidelines.

Younger patients with coronary artery disease and low goal achievement for secondary prevention remain a particular concern. They frequently present with multiple adverse lifestyle factors and carry a high lifetime risk. Improving secondary prevention in this group is important for the individual patient and for society.

What is needed to achieve better outcomes? Multidisciplinary interventions are recommended and have long been in use, but achieving good results remains challenging (6,7). The authors suggest several strategies, including more active referral to cardiac rehabilitation, mandatory registering of rehabilitation options in NORMI, greater involvement of primary care, and increased use of digital remote monitoring. Better utilisation of health promotion centres is also an option.

Digital monitoring should be relatively easy to achieve. There is no need for patients to travel long distances to consult a specialist for advice and information. This can be done just as effectively, and more efficiently, via video or telephone consultations, either nurse-led or through the patient's general practitioner. Digital support and follow-up can also be given for physical exercises carried out at home. Our greatest potential for improvement perhaps lies in expanding the use of digital and personalised follow-up, although further research is needed to determine how digital tools can be deployed most effectively, particularly to reach those who are most in need of support.

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The ESC guidelines also include the follow-up of psychosocial factors as a treatment goal. Patients' ability and motivation to adhere to secondary preventive measures vary, and low health literacy can make it difficult to implement the advice given (4). This applies to both lifestyle changes and adherence to prescribed medications. In challenging psychosocial circumstances where patients suffer from depression and anxiety – which are not uncommon in heart disease – tobacco can be a source of comfort, financial constraints can affect dietary habits, and patients may start from a disadvantaged position for achieving treatment goals. It is therefore essential to recognise and address the whole person. Reaching this patient group requires innovative, differentiated and personalised approaches. The patient perspective must be prioritised, a focus that is increasingly emphasised in ESC guidelines (5). Effective follow-up involves more than merely intensifying efforts on biochemically measurable

parameters. Healthcare personnel need to understand and respect patients' own wishes and values. To achieve meaningful outcomes, the advice provided must be understood and accepted by the patient.

The authors deserve praise for producing a clear and well-structured article that highlights and discusses an important topic in a balanced and constructive manner. The article also demonstrates the enormous value of health registries for research. Significant resources are involved in operating the registries, which contain a huge amount of data. Research using registry data should be expanded, and access to these data must be improved. Bureaucratic and regulatory barriers are widely perceived as a major challenge.

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