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Cielo, Cibele; Silveira, Marlusse; Arboit, Éder Luís; Camponogara, Silviamar

Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:
Cielo, C., Silveira, M., Arboit, É. L., & Camponogara, S. (2015). Expectations of patients submitted to myocardial revascularization surgery at the time of hospital discharge. *Revista de Pesquisa: Cuidado é Fundamental Online*, *7*(3), 2670-2687. https://doi.org/10.9789/2175-5361.2015.v7i3.2670-2687

Federal University of Rio de Janeiro State

Journal of Research Fundamental Care Online

ISSN 2175-5361
DOI: 10.9789/2175-5361

RESEARCH

Expectativas de pacientes submetidos à cirurgia de revascularização do miocárdio no momento da alta hospitalar

Expectations of patients submitted to myocardial revascularization surgery at the time of hospital discharge

Expectativas de los pacientes sometidos a cirugía de revascularización miocárdica en el momento del alta hospitalaria

Cibele Cielo [1] , Marlusse Silveira [2] , Éder Luís Arboit [3], Silviamar Camponogara [4]

ABSTRACT

Objective: recognizing the expectations of patients submitted to myocardium revascularization surgery at the time of hospital discharge. **Method:** a descriptive-exploratory study of aqualitative approach carried out with ten patients in post-operative myocardium revascularization surgery of a university hospital in the south of Brazil. The data were collected from July to August, 2012, through a semi-structured interview and were analyzed based on content analysis. **Results:** the results were grouped into a category that focuses on patients ' expectations facing the recovery process and returning to daily activities. It was found out that this phase is challenging for the subjects, in special with feelings of anxiety and worry about the future, besides having weaknesses in relation to the knowledge about changes of habits imposed by the process of illness. **Conclusions**: surgery causes a significant impact on the patients' lives, thus being necessary the effective intervention by the nursing staff, in order to optimizing the recovery process. **Descriptors**: Nursing, Nursing care, Myocardiopathies, Myocardium revascularization, Patient's discharge.

RESUMO

Objetivo: conhecer as expectativas de pacientes submetidos à cirurgia de revascularização do miocárdio no momento da alta hospitalar. **Método:** estudo descritivo-exploratório de abordagem qualitativa, realizado com dez pacientes pós-cirúrgicos de revascularização miocárdica de um hospital universitário do sul do Brasil. Os dados foram coletados de julho a agosto de 2012, utilizando-se entrevista semiestruturada e analisados por meio de análise de conteúdo. **Resultados:** os resultados foram agrupados em uma categoria que versa sobre as expectativas dos pacientes frente ao processo de recuperação e retorno às atividades diárias. Evidenciou-se que essa fase mostra-se desafiadora para os sujeitos, sobressaindo-se sentimentos de ansiedade e preocupação com o futuro, além de terem fragilidades em relação ao conhecimento sobre as mudanças de hábitos impostas pelo processo de adoecimento. **Conclusões:** a cirurgia provoca um impacto significativo na vida dos pacientes, sendo necessária a intervenção efetiva da enfermagem, a fim de otimizar o processo de recuperação. **Descritores:** Enfermagem, Cuidados de enfermagem, Miocardiopatias, Revascularização miocárdica, Alta do paciente.

RESUMEN

Objetivo: conocer las expectativas de pacientes sometidos a cirugía de revascularización del miocárdio en el momento del alta hospitalaria. **Método:** estudio descriptivo y exploratorio de enfoque cualitativo realizado con diez pacientes postquirúrgicos de revascularización miocárdica de un hospital universitario del sur de Brasil. Los datos fueron recolectados de julio a agosto de 2012, utilizándose la entrevista semi-estructurada y analizados por medio del análisis de contenido. **Resultados: l**os resultados fueron agrupados en una categoría que trata de las expectativas de los pacientes frente al proceso de recuperación y retorno a las actividades diarias. Mostróse que esta fase es desafiadora para las personas, especialmente por sentimientos de ansiedad y preocupación con el futuro, además de tener fragilidades en relación al conocimiento sobre los cambios de hábitos impuestos por el proceso de la enfermedad. **Conclusiones:** la cirugía provoca un impacto significativo en la vida de los pacientes, siendo necesaria la intervención efectiva de la enfermería, con el fin de optimizar el proceso de recuperación. **Descriptores:** Enfermería, Cuidados De Enfermería, Miocardiopatías, Revascularización miocárdica, Alta del paciente.

This is a study prepared from the Work Completion of the Course entitled "Perceptions of patients in postoperative of cardiovascular surgery about hospital discharge: implications for nursing", authored by Cybele Cielo, linked to the Graduate Nursing Course of the Federal University of Santa Maria - RS, 2012.

[1]Nursing. Resident in Cardiology of Cardiology Institute of Porto Alegre. E-mail: cibelecielo@yahoo.com.br 2Nursing, Master in Nursing. Nursing of University Hospital of Santa Maria. E-mail: lussisilveira@yahoo.com.br; [3]Nursing, Master in Nursing. Professor of Cruz Alta University – Unicruz. E-mail: eder.arb@bol.com.br; [4]Nursing, PhD in Nursing. Adjunct Professor of Department and Undergraduate Nursing of Federal University of Santa Maria (UFSM-RS) E-mail: silviaufsm@yahoo.com.br.

INTRODUCTION

Cardiovascular diseases are responsible for one third of the total deaths, becoming a public health problem of first magnitude. About fifteen million people die each year in the world, victims of cardiovascular diseases.[1] In Brazil, this is the leading cause of death, killing about 300.000 people each year.[2] There are characterized as chronic diseases, non-communicable, which cause great impact in people's lives, mainly for employment clearance and the limitation of daily life activities.

The treatment of heart disease can be clinical or surgical, both with the goal of restoring the functional capacity of the heart, in order to lessening the symptoms and providing the individual return to their everyday activities. In this sense, with the advancement of technology, the surgery of myocardial revascularization (CRM) has been characterized as a possibility of intervention, which results in benefits to the patient.[3]

This is a surgical procedure that consists of a process of restoration and preservation of vital capabilities.[4] In the year 2011, in Brazil, there were held about 100 thousand heart surgeries. From these, more than 50% were related to CRM, whose index is comparable to the international literature.[5] Therefore, surgical procedure configures as an opportunity for the maintenance of the patient's life, associated with the needs of facing significant changes in lifestyle.[6]

CRM is gaining space in the Cardiology services, since it is indicated as a treatment for anginal pain, ischemic myocardial protection, improvement of ventricular function, prevention of new cases of acute myocardial infarction (AMI), as well as in the physical, mental and social recovery of the person while improving his quality of life.[7] Thus, patients are often focused on the limitations arising from illness and end up bringing the hope that such limitations will be overcome through the procedure.[8]

Some of the strategies used by patients, aimed at tackling surgery, consist of family support, in the use of spiritual resources and participation in rehabilitation program, which, in addition to the physical conditioning, allow social interaction.[4] It is believed that the procedure is a concrete possibility for extending the quality of life and health of patients with heart disease, including a significant increase in life expectancy of these individuals, which to live more, need to get best health practices that add to their daily life healthier habits and quality of life, to promote their well-being.[9]

In this sense, it becomes important that the health team, in particular the nursing staff, be aware of the expectations and needs of the patient who undergoes a CRM, since this is a procedure that normally generates fear and anxiety. Communication between patient/team is essential for this link, which facilitate the understanding of the meaning of this experience in the life of the user and also to their families.

In this sense, appropriate and effective communication, it gives that patients understand the need to adhere to treatment. That bond is a tool that differentiates the assistance provided, which acquires a most unique format before the needs of the patient/family. The patient with coronary heart disease requires attention of health team in its entirety, since in addition to the incidence and severity of illness, social and environmental factors must be known for professional intervention.[10]

Faced with the problems exposed, the present study has as guiding question: what are the expectations of patients in cardiac surgery postoperative of myocardial revascularization at the time of hospital discharge? In this sense, the objective of meeting the expectations of patients submitted to myocardial revascularization surgery at the time of hospital discharge.

METHOD

This is a descriptive-exploratory study of qualitative approach carried out with ten patients in postoperative period of cardiac surgery of a university hospital in southern Brazil. There was presented as inclusion criteria: patients with 36 to 48 hours postoperatively, being adequate and appropriate hemodynamic conditions in self-orientation and alo-psychic. Were defined as those who do not exclusion criteria if frame on the criteria above.

The data collection took place during the months of July and August 2012, through the semi-structured interview and obeying the appropriate script. The interviews were held in place holder and free from movement. In order to register the full statement of the subject, the interviews were recorded ensuring a rich and reliable material that later was transcribed in full. The closure of data collection obeyed saturation criterion of data.

Data analysis was performed based on content Analysis, [11] obeying the following steps: meeting of the corpus of analysis, realization of floating reading of the findings, conducting in-depth reading in order to constitute categories of analysis, and interpretative analysis of the categories and discussion with the relevant literature.

In conformity with the ethical and legal precepts of Resolutions 196/96[12], yes, it was this that was in effect during the period of realization of the present study. And in order to ensure privacy, the subjects were identified by code and (of respondent) followed by numeric order as the sequel of realization of interviews. The research was approved by Research Ethics Committee, at 6/13/2012, under the number of the CAAE 04135912.3.0000.5346.

RESULTS AND DISCUSSION

The subjects were mostly male (80%). The participants had a variation of age between 33 to 78 years old, with 40% of respondents in the age group of 50 to 60. Most had first degree incomplete and 80% of the respondents played any labor activity, such as agriculture and transport loads. Data analysis resulted in the construction of a category that deals with the expectations facing the recovery process and return to daily activities. This category is divided into two sub-categories: challenges after surgery and the return of everyday activities.

Expectations before the recovery process and return to daily activities

Challenges after surgery

Many advances have taken place in cardiac surgery, making the surgical correction of a variety of cardiac lesions a viable therapeutic option for an increasing number of patients with cardiovascular diseases. Despite the increase in risks, particularly related to age and advanced disease, cardiac surgical patients currently enjoy better conditions of surgery, than when compared to those operated for ten years.[13]

However, it was observed that the illness is a milestone in the life of the subject, and from that moment on, a new journey begins full of challenges and adaptations. When questioned on how they imagine their lives after surgery, one realizes that the subjects were anxiety and concern for the near future, because they believe that will lead a life somewhat suffered due to limitations imposed by illness. The following statement explains this reality:

> *Will be suffering [...] I don't have patience to stay at home, the anxiety makes fat, that is my fear [...] changes everything [...] then it will be difficult [...] I'm going to have to face. (E2)*

Cardiovascular problems interfere heavily in the live mode, because there is a need for restructuring in their lifestyle. Therefore, it is evident that to the deponent, your life will be difficult after surgery, having to face it anyway. Become a carrier of chronic disease means bring with different tasks, which usually interfere with the way of life of the patient and family. In this way, it requires both visualizing and understanding new condition for that, so they can live and face the context of life brought by the disease.[14]

The acceptance of a chronic disease is a challenge since many determinants contributing to non-adherence to treatment. Among them are: lack of knowledge about the disease, or motivation to treat asymptomatic and chronic pathology, low socioeconomic status, cultural aspects and beliefs, low self-esteem and prolonged service time, difficulty

in appointments, lack of professional contact with individuals absentees, loose coupling with the health team, among others.[15]

The adoption of healthy lifestyle habits, changes in diet, physical activities, the correct use of medicines and self-care are seen often as difficult tasks, imposed by illness. Patients may deny the change arising from limitations that illness brings, so denying the disease too. Many seek in their daily activities continuity proof that the disease doesn't hit them, trying to prove to themselves that the body is still healthy.[8]

The diagnosis of coronary heart disease provides, to the patient, feelings of great emotional distress by reason of fear of death, to be invalid, the unknown, of solitude, of depression and anxiety, since the heart is regarded as a noble and vital organ. It is believed that these feelings, on the one hand, leverage the stress and anxiety, aggravating the clinical picture; but, on the other hand, may encourage the immediate practice of self-care.[16] The experiences of disease and cardiac surgery marks a break in the way of living, working and understanding the health-disease process.[13]

It is observed that the physical marks left by the surgery also generate suffering. Surgery gives right status and the scar represents the brand that the patient is a survivor, recalling the idea of rebirth. At the same time, the incision may represent the mark of the body was violated, that the integrity of the body was torn, generating misery and expectations in relation to the quality of life and work return.[17] Such concern is highlighted in the demonstration below.

> *I think it is complicated to work again, it's hard to ["...] it was already struggling and now with all this then who will give service to a guy like that "? Who wants a man chest pain, with all these cuts there? (E2)*

These marks, that will accompany them throughout their lives often bring, the thought, the memories of that time, which may also contribute to weakening of these subjects. Thus, the context of the disease, not rarely, brings to the patient life an aspect of embrittlement, because the disease doesn't put just the threat of actual death, but also ends up causing several losses that result in experiences of “symbolic deaths”.[18] The work in this context is understood as an essential condition in the process of living; both the feelings of uselessness and disability arising from the inability to be productive are embarrassing for the subject. One can deduce that, despite being a therapeutic cardiac surgery which results in advantages in terms of quality of life, may impact significantly on the patient's life, and often, with scary aspects.[19]

Dependence on others for activities of daily life was also a problem to be faced in the rehabilitation period, especially in the sense of taking the disease imposes limitations and adopts changes in lifestyle. The following statements explain better this issue:

> *Only now with this situation will be difficult [...] so I'm a little concerned and I don't even have time to retire. (E2)*

> *Already changed [...] to think that I won't be able to do what I want (work), which is the most common thing, you already is [...] withdrawn [...] instead of I do I'll have to send someone to do. (E1)*

When people are not able to perform activities with the same quality as they feel devalued and unsatisfied, leading to changes in the perception of their role within the family, professional and social context. This condition causes dependency conflicts that are configured as loss of autonomy brought about by the reduction of physical capacity, undermining the aimed goals[21]. It is believed that initially the extent of dependence of these subjects is larger, requiring even more of the help and support of family members and health professionals.

However, it is crucial that, after that period, subjects to acquire autonomy and resume gradually, to perform tasks of daily life. From the conjunction of these factors is an impasse. It is necessary that individuals maintain their plans and their trajectories, so that there is a sense of continuity in their lives. However, such trajectories can no longer be the same previously thought and need to be re-signified. The impossibilities of the body require such (re) significations, which are not easily constructed by individuals.[8]

Before the suffering experienced in the immediate postoperative period, one of the interviewees was decided to abandon the habit of smoking.

> *Means everything, a change [...] I smoke, I drank, and now I won't do [...] I smoked until the day before the operation [...] gives more value to life [...] after I was operated became suffering, sadness. (E2)*

Crisis situations and anxiety as to hospital admission, it can motivate patients to quit smoking making them aware to other changes. However, abstinence may trigger irritability, restlessness, poor concentration, depressive symptoms, plus other signs/symptoms. Thus, the period of hospitalization may be used by the multidisciplinary team, to sensitize patients and family members to abandon the habit.[16]

In this way, one can see that, when it occurs, the insertion of these patients in rehabilitation programs, to adapt the changes becomes a less strenuous process and assists them to show this near future as an opportunity for change, they bring a life with more quality. It should be noted, in this context, the importance of differentiated look for each core professional multidisciplinary team for the patients, who ratifies the need to extrapolate the barriers of cardiovascular disease.[18]

Considering these factors, it is up to health professionals provide guidance on the essential practices of self-care post-surgical mainly because some people consider the absence of symptoms as meaning of healing, allowing yourself to live dangerously, "that is, enjoying pleasures" banned "for those who have already submitted their statements 15 cardiovascular changes below demonstrate this.

> *For me will be normal, as was. (E10)*

> *I have to take care for at least two to three months [...] have to take care of the food, I can't force it [...] leisure that we had [...] will differentiate one way [...] but to old man, retired, but any job you have to do. (E4)*

Often, after the acute episode, the practice of self-care can be abandoned or followed by irregularly by usuários15. Commonly people resort to medication when they realize any physiological change. This behavior represents a deficit in self-care, which can

lead to numerous complications or injuries in target organs, and is accentuated when the individual makes use of large number of medicines, as in the case of postoperative patients of coronary artery bypass grafting. However, one should also pay attention to the fact that some guys, don't compare your ability after surgery to the pre-surgery period, but the period prior to illness.[8]

Note-If an expectation that surgery bring another possibility of life. In this context, the prospect of some patients about the results of surgery is not always realistic. What can also make this difficult is the fact that they think, for the rest of their lives, will have to obey the orders of others, especially doctors, as seen below.

> *I'll try to take her, as the doctor says, if he say you cannot eat fatty meat, you can't do this or that, I'm not going to do more [...] I'm going to have to respect the doctors [...] everything will be different now. (E5)*

> *I imagine it will be a more careful life [...] if he (doctor) told you can't eat fatty meat, won't eat [...] will not boot this hustings I leave [...] so I am well aware; I have to take care of myself. (E7)*

It is believed that gets more difficult adaptation to care when the changes start from third parties and not from this own person. However, displayed often, that medical practice, as well as other practices performed by other professionals in the area of health, focuses on their actions on apprehension of what cut as health needs objectively. However, this encompasses all not clipping and the complexity of the person's health problems, since the same is hardly heard about establishing priorities for their own health.[20]

That way, they can only make truly free choices people who understand what's happening in your own body, that follow no rules because these were imposed by any professional, but because they understand and know that they broaden their potential of being happy.[21]

The phase of recovery and rehabilitation of the individual (re) vascularized is very important. The goal of cardiac rehabilitation is not only improve cardiovascular functional capacity, with improving the quality of life, but also controlling coronary risk factors, reducing the likelihood of recurrence and decreasing the morbidity and mortality. To promote rehabilitation after myocardial revascularization, people need to often change behaviors to quit smoking, manage stress, change in diet and take on new tasks such as: the practice physical exercises and use medicines.[13]

In this sense, one can see that, some guys, they already have that notion at the time of the interviews.

> *Means that more and more I need friends and people [...] I have no words to say everything that I feel. (E8)*

> *Will be practically another life [...] won't be able to force more, I won't be able to drive [...] no way to the truck [...] trying to lose more [...] have a better, healthier life. (E1)*

> *That will change will [...] work no more, I want good life [...] but good life I say is so, isn't it party and thing, it's to stay at home, see the relatives who live all around and we don't see. (E6)*

In addition to tracking what changes will be needed, right now, those guys are seeking also resign their networks of social relations. Thus, surgery can also be conceived in its aspects enhancers, serving as a means from which the subject can rearrange their lives and their relationships.[22] The conscience of greater care with you and with the other, seems to get registered in the above statement, highlighting the constructions that happen throughout life in their procedural aspects.

On the other hand, there may be certain strangeness of the subject in relation to experiences with the new body, its potentialities and limitations. In other words, the procedure seems to permit a reassessment iffy about using their own bodies.[8]

> *Maybe I will take more care about myself [...] not to do certain labor camp [...] I imagine it will be ruled anymore [...] I'm not working as hard as I've worked until today. (E8)*

> *I don't know [...] I hope this is better, but I don't know why I suffered very [...] that I don't feel pain. (E3)*

In front of the expressions "maybe" and "don't know" seems to be no doubt on the part of the subject, on their ability to recognize its possibilities and limitations. After the procedure, which seems to be at stake is a process of recognition of oneself, the limits of the body. Bodily integrity is meant as broken and such reality seems to be reflected, sometimes unable to carry out plans for the future. It is the experience of a process of adaptation of expectations prior to surgery, which intrinsically seems to depend on the references of each on the process.[8]

The return of the daily activities

In this subcategory will be discussed some aspects related to work, recreation, physical activity, nutrition and sexuality. It is evidenced that for the working population, the inability to work arises as a prerequisite for the recognition of the disease. The work, in such a context, has a significant weight, as the body is a source of livelihood. Failure to do this may bring feelings of social disintegration and loss of identity, to the extent that work is the means by which the subjects have their recognition as such.[14]

Given this, one can see that, for the respondents, the work has a special meaning in their lives and when questioned on this point, after surgery, are thrilled to think they can no longer exercise it.

> *I'm going to tell you [...] will be hard to stop [...] I'll tell you if I could go back to work tomorrow I would [...] just doesn't have conditions. (E6)*

> *I imagine it's going to be hard (crying) adapting at the beginning. (E8)*

> *I think that bad [...] I always worked very hard [...] and is not to say that I worked on, the clock, heavy duty, ill [...] doesn't help health today! (E2)*

> *Look it's going to be difficult for me [...] I'm going to see if I change the way of living. (E4)*

> *The doctor told me I can't carry weight, heavy lifting, you can't do anything else [...] I'm going to try to enter to justice to retire. (E5)*

Cardiovascular disease, increasingly, reach a population young and productive age. This fact triggers large impacts in the lives of these subjects, since work gives people financial independence and social identity. The testimony of those emotion overtake, to address this subject and the anguish in the belief that they cannot perform more tasks and activities through which their moral identities.[14]

In addition, these testimonials show that respondents play family-oriented roles, dedicating him to maintaining his home and watch his family. See, this way that the illness also raises implications for the lives of people who live and depend on these subjects. This fact, depending on the singularity of each one, can be a stressor, which, in turn, can encourage the emergence of new heart complications. Therefore, these patients require support on psychological and social sphere, to deal with stressful situations and live with chronic illness.[8]

There are conceptions of the body as an instrument of work and normalcy shall be subject to the physical and mental ability to work, present in the urban-industrial and capitalist societies that displaces common sense and also healthcare.[23] These conceptions, based on economic rationality, diffuse into other, denoting the head of family dishonor incapacitated for work and embarrassed in front of their dependence and of the financial difficulties the family.[24] In a brief manner one of the subjects exposes this concern.

> *I think that I won't be able to forcing any more [...] has to have a limit [...] I'm going to put a person to help me. (E10)*

It is therefore considered that relying on others, possibly, accentuates the feeling of helplessness of individuals. Faced with the impossibility of performance of tasks from which previously were recognized, there seems to be a need for other parameters of social recognition that are constructed.[8] In that regard, it is understood that the extent of the work can be linked to material well-being, in turn understood as a necessary condition for the promotion of independence and autonomy.

Surgery seems to be perceived by the subject, as associated with the limitation to labor activity, and there are psychoemotional importance of the situation, repercussions in terms of perception of low self-esteem and financial dependence,[25] as can be seen below.

> *I think the work will be a bit difficult [...] says he can't force, I think you do the readings at home can huh? [...] but I don't know, I don't know anything. (E3)*

> *Work, won't give more [...] nobody talked to me [...] will depend on what the doctor will say after I'm well healed [...] let's see what he will say. (E9)*

However, we see the hope on the part of respondents, when they deal with not knowing anything, but everything will depend on physician's guidance. To do so, cultivate the hope that may return to perform some activities brings them comfort. It is therefore important that, from the earliest days after discharge, these patients have already notion that may, to the extent possible, perform small tasks that make him feel participants and

valid vis-à-vis their own self-care and daily chores. With each passing day, progressing well his health framework, the return to labor activities that do not require physical exertion to beyond the capabilities of these subjects will be gradual.

Another aspect mentioned by the participants of this study, refers to leisure. The surgery seems to putting the subjects faced with a reality in which the bodies, and therefore, their lives, are no longer intact. Accordingly, the procedure, to confronting interviewees with this finitude,[19] seems to mean a breakup. The subjects reported that plans can no longer be made, because the surgery refers to the fact that no one can be more certain about life.[8]

Moreover, from what these interviewees consider leisure, after surgery, this may no longer exist, as seen in the testimonials.

> *Leisure is the family, home, barbecue, fishing in the summer, that there. (E1)*

> *I liked being in a bocce court playing in a bar, in a river bathing [...] but slowly I'm going to have to change, no point [...] we'll see what the doctor will tell me when I get discharge. (E5)*

In the last statement, we observe that the subject is restricted/dependent on medical guidelines so that, from them, can make their choices. Thus, at first, the understandings of the limitations seem to be rather blunt in various aspects of the life of the subject. Such limitations seem to be meant as a disruption of the daily flow of their activities, generating a movement that brings the depressive aspects.

Such aspects are not necessarily considered negative, as it may imply a reflection, questioning character parameters according to which the conduct of life is held by respondents.[8]

> *It's now game of boules that I liked I can't [...] but then over let's see how it goes! (E7)*

> *I like working and staying at home. (E10)*

> *Liked to play the game of boules [...] I think I'm going to have a quiet life, kind of hard [...] you off work and in a week for another you plant for indoors and not being able to get out more. (E2)*

Before the testimony of life after discharge, will be peaceful, it is believed that these guys consider their labor activities only as means of recreation. Therefore, it is impossible to do so; the subject doesn't meet/consider other activities requiring less physical exertion/non-profit recreation practices. It was found that the majority of respondents reported not having any kind of leisure. This behavior facilitates the emergence of stress, which can be associated with other risk factors and cause cardiovascular changes.

Leisure was represented by some of the subjects, as a hobby or as escape from loneliness, since some mentioned get spaces to allow them to relate to other people. The majority of respondents conceive leisure activities as something futile, devoid of a meaning that bring well-being and health, as if viewing the following statements.

> *I think it will be good. (E3)*

> *Will differentiate unclearly [...] I have a bar, it's going to be pretty bad, but I want to see it keeping [...] since this happened, I did not expect, let's see if I change my life. (E4)*
>
> *It's going to be good, has two markets there close to home, in a morning newspaper and afternoon going to the other, and step over there, hovering. (E6)*
>
> *Looking to live life more and work less. (E8)*
>
> *"I think I will continue [...] I'd like to go in the CTG (Gaucho Traditions Center) dancing. (E9)*

In this sense, the professional nurse, along with the other members of the health team, must act in partnership with the family, the encouragement and promotion of recreational activities, with the aim of reducing the stress and normalize blood pressure, thus minimizing the risk of complications and encouraging the improvement of the quality of life.[16] In this way, physical and leisure activities should be stimulated by the professionals, and perceived by patients as something integrated with life, in a natural way. This may indicate that, for the exercise of autonomy in daily life activities, reflects good health.[25] States promote health means, therefore, strengthen the balance between all related factors, including leisure activities. The way the individual deals with his own body and his health condition is what determines his behavior and choices.

There are evidences showing that the practice of physical activity is beneficial in primary and secondary prevention of cardiovascular disease, as well as on health in general[25]. In recent decades, physical activity has been incorporated in the treatment of patients with cardiovascular[30] disease being beneficial in postoperative cardiac rehabilitation.[26] Noted that the subject of this study did not have the habit of such practice, relating the activities of work with physical exercise, as noted below.

> *Just run, run every day; truck so it was just what I was doing "E6."No, it's not, just service, but don't stop. (E4)*
>
> *Almost all exercise I did within the firm working. (E9)*

At this point in time, these guys, consider his work as the only physical activity developed in their day to day it was noted that the physical exercise were restricted to industrial activities, in the absence of a more specific design of body movement beyond the desktop. Physical inactivity has been considered an important risk factor of cardiovascular disease, being an ally in the activities of disease prevention and health promotion.

Once that physical activity has many health benefits, it is reasonable to assume that she too can become a factor of protection for patients who are candidates for surgery and CRM not only as rehabilitation after the surgical procedure.[27] The study[38] showed that, at the same time, there is a positive effect of cardiac surgery in the promotion of healthy lifestyle habits in relation to the practice of physical activity, who went on to be performed more frequently, after the surgery. Although the investigação28 point the benefits of physical activity, which began even before surgery, this reality is not yet common in our environment.

It was noticed that although patients report difficulty fulfilling this practice of self-care, you guys already aware about the importance and need to exercise it. It is observed that physical activity is not seen as a form of welfare / quality of life, but as a condition imposed by illness, namely, the encounter with the illness the subject finds himself compelled to practice some exercise.

> *Oh, I'm going to have to do something [...] to start can't fatten [...] I have to control myself, and do some exercise, some hiking [...] now the same health requires you to do this. (E6)*

Yet there seems to be some difficulty in understanding the general population, that physical exercise should be a regular activity. It is believed that the practice of daily physical activities produces beneficial effects, such as decreased anxiety, reduces emotional stress, lowers the metabolic disorders and improves vasodilation ability in different vascular beds.[25] Some guys are believed unable to practice physical activity.

> *Yes that's the [...] I just walked or rode a bicycle [...] but I don't intend to do that I have great difficulty in the legs. (E2)*
>
> *I was at the gym [...], because now I don't know if can do. (E3)*
>
> *It's complicated [...] no point [...] I ran up before doing the surgery and now I can't even run more. (E5)*
>
> *For now I still didn't speak about. (E9)*
>
> *I haven't figured that out yet. (E10)*

In counterpoint, one must give attention to these statements because, for many people, physical activity is not well accepted. Surgery may be for these guys, an argument which prevents them from serving them. In addition, to feel relatively well, it may not realize the need to change his usual life style, since the change in living habits is difficult, remaining as major challenge.[29] May say that educational approaches, at the time of hospital discharge, encourage changes in lifestyle, including the practice of regular physical activity, which has a favorable influence on surgery, and can be a boost for the restructuring of the everyday life of these subjects.

Another aspect that has fundamental importance for people undergoing myocardial revascularization is related to food. For the subjects of the study, it is evident that it will require a restructuring of eating habits. However, this need for change imposed by disease condition itself, brings stress, because desires are repressed and people are divided between the craving and the ban, knowing that if they break the diet, may suffer damage.[16]

At the time of hospital discharge, the subjects believe that will be required changes in eating habits, what their minds.

> *Because it is [...] this will be different [...] salt for me is poison, I am terrified of salt [...] now I love fat. (E4)*
>
> *You're going to have to change [...] slowly the man will [...] don't have who do not change. (E5)*

> *I think it will be difficult [...] I ate fatty meat and was fried cassava, all swimming in grease [...] and now nothing more [...] the man becomes sad, see others eating and not being able to eat. (E7)*

Change eating habits, appears in the testimonials, as one of the biggest challenges that must be overcome by the subject. Palatable preferences are closely linked to the Customs transmitted for decades and propagated between generations, traditions favoring the predilections by a particular palate. Thus, the palate is not easily changed by public policies, based on the medical argument that certain foods have higher nutritional value. The cultural elements of those are developed through a thorough process and, therefore, it is not easy to demystify some of the same concepts and attitudes in relation to health behavior.[29]

Therefore, the reduction of body weight can be obtained by reduction of caloric intake, especially carbohydrates and lipids. However, the practice of self-care demonstrates that it is not enough to reduce the weight, the ideal is to keep it in adequate levels for long term, requiring the incorporation of healthy eating habits, with individualized dietary guidance, considering the motivation of patients and the socio-economic and cultural aspects, such as: financial resources and food preferences.

Therefore, at every opportunity, the health professional must encourage self-care activities governing the functioning of the organism, aiming to fix the body weight, demonstrating the advantages arising from this attitude, such as lowering blood pressure, better physical appearance lower rate of cholesterol, triglycerides, uric acid and glucose.[16] Another difficulty relates to the reduction of salt in food.

> [...] I can't eat few salt and can't spend a weekend without a bit of flesh [...] I think it's going to have a change that [...] but they still haven't told me anything. (E2)

It is understandable therefore, that would be less arduous these changes for patients with cardiovascular disease when, along with him, the family adopt a healthier diet. Soon, it is understood that the cultural process feed is associated with a thorough follow-up of elements inside, difficult to demystification in relation to the behavioral changes of feeding.[26]

However, all of these guidelines will only be effective if, before you provide them, the professional is able to elucidate the cultural memory feed on its customers, understanding the customs and the multiple relationships between biological and socio-cultural, gustatory preferences; once the food selection transmitted over several generations internalize habits, tastes and concepts have to deep root. It is evidenced, then, in the usual Brazilian culinary palatable memories a predisposition for excessive sodium content foods, starches, fats, which transmit sensations as satiety and pleasure. Becomes necessary a change in culture in order to improve the task of guiding and promoting effective changes in the process of food reeducation and prevention.[26]

A last point covered in this study, but no less important, is related to sexuality, constituting a subject considered a social taboo, being, his approach with the patient, normally difficult. The patient may feel embarrassed or ashamed to speak on an issue which revealed aspects of their intimacy. Moreover, this theme is not always addressed by the health team.[8]

It is observed in the demonstrations below the confirmation of this problematic, among patients who perform heart surgery.

> But I think it's normal, I think [...] didn't tell me anything [...] waiting to see now what the doctor will say: if it's normal or will change anything. (E5)
>
> Normal [...] I think [...] don't know. (E3)
>
> I did not think. (E4)
>
> Never crossed my mind [...] not guided. (E6)
>
> That, the doctor will tell you how it will be [...] but I haven't talked to him in this part. (E8)
>
> I don't know how it will be. (E9)

It displayed the uncertainty if your sexuality will be impacted or not after surgery. Await medical guidelines against this subject, at the time of discharge. However, so shy, in the second manifestation the patient says not having thought of it so far. It is evidenced thus that sexuality remains a taboo subject. How this issue is handled suffers the influence of biological aspects (anatomical and physiological), psychological (environment, education, personality, emotions), cultural (values), subjective and social.[27]

From the premise that sexuality involves the body, one might think the repercussions of surgery with regard to body image as affecting also the form of management with sexuality. However, if the subject perceives itself as a body sick, invaded and bullied by surgical intervention, there's no way the understanding and experience of sexuality not to be contaminated by such perception.[8] In addition, cardiovascular disease interfere with sexual activity of patients and, in the vast majority of the time, acts as a complicating factor. This is justified by the necessity of use of various drugs, capable of producing adverse effects that impair sexual performance (especially by the triggering of erectile dysfunction and/or loss of libido).[20]

Another aspect which refers to illness, to study participants, refers to the body's own limitations on ability to sexual performance. In the account below pops up that the disease brings real limitations to the exercise of sexual activity, perceived even before surgery.

> I already had a bit of trouble after I had blood sugar [...] but I thought in retrieve [...] about it I don't know, I'd like you to stay normal, but will know [...] that I don't know. (E2).

Subtly the subject States that already had difficulties before the surgical procedure and that, after it, demonstrates uncertainty if indeed would be normal. Being the most subjects male, it was observed that this reality is reported with a certain parsimony and difficulty by the participants, denoting be difficult to exposing aspects so close;[27] once, for men, especially, sexual performance is very linked to the affirmation of his manhood. In this context, one can understand the ambivalence in the manifestation, in which the participant speaks of sexual difficulties of superficial way, easing the reporting of its limitations in this sphere.[8]

Sexual activity is conceived as physically exhausting and, not infrequently, as a possible trigger of cardiovascular events. Thus, it is considered the need for a multidisciplinary approach in the rehabilitation process,[8] being necessary that these matters are approached with more peace of mind by professionals from the health teams. In another report, the concern becomes apparent.

> We know we have is not normal [...] can't do much effort also [...] but it was not said anything yet. (E7)

So, here is an important consideration. The guidelines about sexuality should be part of health care and should be extended to the patient's partner. It is in this way, when they say that patients should receive guidance on sexual activity in the same way they receive information on return to work and about how they should engage in exercise programs.[20] The spouse must be informed about the situation of the partner to the fullest extent that advice possible.

The nurse while Manager of nursing care and for being a dynamic professional need to know the various ways to assess and understand aspects related to pain, work, recreation, physical activity, nutrition and sexuality. He needs to get to interact with the team to discuss and intervene with interrelated actions in favor of optimizing quality assistance to post-surgical patients of CRM, providing thus greater possibilities for quality care.

Before the results of this study, reaffirms the idea that inside the hospital, the warning depends on the combination of the work of various professionals.[31] I.e. the care received by the patient is the product of a large number of small partial care, which will be complementing. Thus, this research aims to contribute to this process by demonstrating some possibilities to nursing staff and other health teams operating in this scenario to forge a network of assistance and care increasingly integrals.

CONCLUSION

The present study revealed the expectations of patients submitted to myocardial revascularization surgery at the time of hospital discharge. In this context, it was observed the little understanding of respondents in relation to the surgical procedure and the care after discharge, which denotes a reality troubling, because the lack of information about this pathology as well as domiciliary care can be frequent cause of future interactions and still focusing on declining quality of visa and health of patients.

The subject report, previously the surgery, had active life and, in many cases, work overload, considered inappropriate eating habits as meals rich in fats, fried foods and with excess sodium, beyond the consumption of alcoholic beverages and tobacco. Thus, the change of feeding behavior and reduction/cessation of such "habits" by the awareness is the key point to a change in lifestyle. Another important situation highlighted is that some of

the subjects have little understanding of the importance of physical activity and recreation for the improvement of the quality of visa postoperatively. Often the subjects avoid talking about sex and refer to fear regarding sexual practice after surgery.

The proper nutrition, drug treatment, physical activity and cessation of habits like smoking and alcohol are as important possibilities for maintaining the health of individuals (re) vascularized. In this way, increasingly gain independence in their duties, limitations will be overcome and, perhaps, reconquering their financial independence and social recognition. Thus, the knowledge of the factors that interfere with health satisfaction among people with heart diseases becomes thus an important tool for planning social policies geared to these users and focused on their quality of life.

Thus, although sexuality is included in assistance plans; it is known that, to experience the chronic illness and throughout the hospitalization, users build myths, taboos, prejudices, sexual concerns front reflecting directly on the married life and in their body image. Once this fact can bring suffering to those subjects, it becomes important that professionals gain more knowledge and to explore the representations, the meanings as well as know how the patient acquired information about or how it was built his sexual identity.

Regardless of the individual nuances of reports that make up this study, a trait seems to cross them: it is evidenced, in depositions, or reactions to researchers, the experience of a significant amount of suffering. As a result of this evidence, it becomes necessary to rescue the importance of reflection on aspects of surgery that are beyond physical illness. Such issues should be emphasized and more widely worked in the most diverse, embracing interdisciplinary professional areas and knowledge that purport to welcome and take care of the Brazilian health system users. Thus, this study shows that care must be large, since it needs to address issues pertaining to the work, power, sexuality, physical and leisure activities which appear to have greater impact on the lives of these subjects.

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Received on: 11/03/2014
Required for review: No
Approved on: 29/10/2014
Published on: 01/07/2015

Contact of the corresponding author:
Silviamar Camponogara
Rua Visconde de Pelotas, 1230/201 . Santa Maria – RS
Cep – 97015-140.
E-mail: silviaufsm@yahoo.com.br.