Working ability and coronary heart disease

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KEYWORDS: coronary heart disease, exercise test, work ability/disability.

CITATION: *Cardiol Croat.* 2015;10(9-10):218. | **DOI:** <http://dx.doi.org/10.15836/ccar.2015.218>

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Coronary heart disease causes more deaths and disability and incurs greater economic costs than any other illness in the developed world. It is logical that this impact reflects on the working capacity of the individual. The frequency of returning to work varies greatly in the world, depending on the type of health insurance, duration of rent, the labor market and sick listing traditions among physicians.

The aim of modern therapy is to improve quality of life and the renewal of professional activity.

Work ability depends on the health conditions and circumstances of the workplace. Presence of chest pain during exercise, risk of arrhythmia and a high level of left ventricular dysfunction are the main symptoms indicating a working disability.

The most reliable test for assessing work capacity is the exercise test, but the results of this test should always be carefully analyzed. Functional assessment of the heart muscle is not always based on a strictly scientific basis, varying from examiner to examiner. The authors proposed when assessing coronary reserve that the upper general tolerance limit over on 8 hour work day consisting of mixed physical labor including manual handling operations, should be 40-45% VO_2 max. while exposure to short-time work extension may be allowed 70-80% of the end-point level of the exercise test.

The assessment should take into account that persons who take up active work after a myocardial infarction have a longer life span, a five times smaller percentage of neurosis and depression in relation to retired reconvalescents, and a significantly lower probability of developing a recurrent cardiac incident. Most often return to work the younger age groups, highly educated, highly educated, employed preoperatively.¹⁻⁴

Assessments of working abilities should be made after the completion of treatment and rehabilitation, while taking into account all of the parameters so as not to harm the truly disabled.

RECEIVED:
September 15, 2015
ACCEPTED:
September 17, 2015

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