



**PROPOSED REVIEW OF SIGN GUIDELINE  
CONSULTATION FORM**

Title of guideline	SIGN 57:Cardiac Rehabilitation
Date of publication	2002
SIGN scoping search – sources	MeSH headings for the condition specified, plus any common variations as free text  Sources: <b>Guidelines:</b> NICE; National Library for Health guidelines finder; National Guidelines Clearinghouse; GIN Web site. <b>Technology appraisals:</b> NICE; UK HTA database (Southampton); INAHTA database. <b>Cochrane reviews:</b> Cochrane Library. <b>Other good quality systematic reviews:</b> UK HTA database (Southampton); DARE. <b>Individual studies:</b> Cochrane Register of Controlled Trials.
SIGN scoping search - summary	<b>Guidelines – 5</b> <b>HTAs – 0</b> <b>Cochrane reviews – 14</b> <b>Other good quality systematic reviews – 3</b> <b>Individual studies - 82</b>
Other guidelines/HTAs	<ul style="list-style-type: none"> <li>▪ <b>Finnish Medical Society Duodecim.</b> Physical activity in the prevention, treatment and rehabilitation of diseases. In: EBM Guidelines. Evidence-Based Medicine [CD-ROM]. Helsinki, Finland: Duodecim Medical Publications Ltd.; 2004.</li> <li>▪ <b>Institute for Clinical Systems Improvement (ICSI).</b> Diagnosis and treatment of chest pain and acute coronary syndrome (ACS). Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2005.</li> <li>▪ <b>NHS Modernisation Agency.</b> Coronary heart disease collaborative service improvement guide: rehabilitation. NHS Modernisation Agency, Department of Health 2002. Leicester.</li> <li>▪ <b>National Collaborating Centre for Primary Care.</b> Post myocardial Infarction secondary prevention in primary and secondary care for patients following a myocardial infarction. Draft for consultation. <b>NICE Guideline.</b> August 2006. Final version to be published March 2007. Includes cardiac rehabilitation.</li> <li>▪ <b>New Zealand Guidelines Group (NZGG).</b> Cardiac rehabilitation. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2002.</li> </ul>
Main conclusions from new evidence	<ul style="list-style-type: none"> <li>▪ A Cochrane review concluded that psychological interventions, including stress management, showed no evidence of effect on total or cardiac mortality, but did show small reductions in anxiety and depression in patients with CHD. <i>Guideline supports inclusion of psychological interventions in cardiac rehabilitation (A); stress management not specifically discussed.</i></li> <li>▪ An RCT demonstrated that a brief intervention during hospital admission after MI and bypass may have insufficient power to influence highly dependent smokers to quit. <i>Guideline states (2.6.1) brief advice from a health professional can increase rates of smoking cessation. No recommendation made.</i></li> <li>▪ Telephone counselling intervention can improve self-rated health of cardiac patients. <i>Not discussed in guideline.</i></li> <li>▪ Two systematic reviews identified potentially modifiable barriers to and factors associated with cardiac rehabilitation adherence/attendance. One RCT evaluated techniques for patient retention. Another RCT concluded that self-monitoring may increase exercise maintenance and physical activity during cardiac rehabilitation. <i>Compliance with rehabilitation programmes is discussed briefly at points throughout the guideline. Guideline recommends that rehab staff should identify cardiac misconceptions in patients with CHD (B), with the implication that these reduce compliance. There is no identification or discussion of how to address specific barriers.</i></li> <li>▪ An observational study in the UK found that use of The Heart Manual significantly reduced anxiety and depression and was suitable for use in patients over 80 years. <i>Guideline recommends use of the Heart Manual (A).</i></li> <li>▪ Several studies validate/evaluate and recommend HADS, CDS, or CD-VAS for assessment of depression in cardiac patients. <i>Guideline recommends screening for a validated assessment tool “such as HADS” (B).</i></li> </ul>

	<ul style="list-style-type: none"> <li>▪ Three observational studies found that spousal attitude and levels of social support are associated with prognosis and outcomes of MI and HF patients. <i>Role of social support discussed, but no recommendation.</i></li> <li>▪ A 2004 meta-analysis concluded that post-MI depression is associated with 2 to 2.5 times greater risk of mortality in contrast with earlier studies. <i>Guideline cites 3 to 4 fold increase in mortality (2.1.1).</i></li> <li>▪ One systematic review discusses evidence concerning information needs post-MI. <i>Guideline provides notes for discussion with patients without citing supporting evidence.</i></li> </ul>
New areas that could be added to the guideline	<ul style="list-style-type: none"> <li>▪ Identifying barriers to patient engagement/improving adherence to rehabilitation</li> <li>▪ Dealing with stress/importance of social support</li> <li>▪ Information needs of patients</li> </ul>
Summary of the recommendations that could be updated	<ul style="list-style-type: none"> <li>▪ Recommendation on screening tool for anxiety and depression</li> </ul>

Please answer the following questions as fully as possible:

Name, designation, organisation:	GP: 1 Nurse: 1 Other: 3 Academics: 1 Consultant: 1
1(a) Is there still a requirement for an evidence-based guideline on this topic?	
	<p>Yes = 7</p> <p>definitely yes. Important to maintain high standards and ensure equity of service provision.</p> <p>I would presume so but clinicians on the guideline group would be better placed to answer this question.</p>
1(b) If no, should the guideline be withdrawn?	
2(a) Do you agree with the assessment of the impact of the new evidence and its likely effect on recommendations?	
	<ul style="list-style-type: none"> <li>▪ Yes = 4</li> <li>▪ Using the SIGN process the new evidence is likely to have very little impact on the current recommendations</li> <li>▪ Yes, particularly important to address patient engagement with rehab as this is a common problem for services across Scotland and the use of innovative methods and a variety of rehab models should be encouraged. Also a need to particularly focus on the needs of the younger population and women as this group remain under-represented in traditional rehab programmes.</li> <li>▪ Cost effectiveness is not specifically addressed above, however I have had a brief look through the literature that has been published since which has considered cost-effectiveness. In particular, the NICE clinical guideline provides a good summary of the issues. They summarised the published economics evidence and also undertook a health economic analysis in light of recent results from meta analyses. The key message from this analysis was that cardiac rehabilitation is cost effective compared to no cardiac rehabilitation. They provide cost per QALY estimates that would add to the literature which was discussed in the SIGN guideline</li> <li>▪ Recent CHD guidelines included the Cochrane review on interventions mentioned above and contain recommendations on stress and social support, so no need to add this. Barriers to engagement/improving adherence were also touched on in some of the recent guidelines e.g. Heart Failure, though would have been useful in a rehab guideline. Unless there are direct comparisons between HADS and other screening tools, I doubt we would change the current recommendation</li> </ul>
2(b) Based on the information given above, and your own clinical judgement, does the guideline require revision in the light of new evidence? Please give details.	
	<ul style="list-style-type: none"> <li>▪ Yes = 4</li> <li>▪ No = 4</li> <li>▪ as not convinced that the recommendations are likely to change</li> <li>▪ There needs to be improved guidance in assessing and treating the presence of adverse psychological reactions and as above, compliance is a major issue for many traditional programmes and there should be firm support for the menu-based approach, which encompasses traditional classes, independence rehab, varying times and locations etc. cardiac rehab needs to adapt to the changing needs of a younger population and a higher number of women; also considering the many different cultural approaches.</li> <li>▪ The health economic section of the guideline could be updated to reflect the new health economic analysis, but the overall message from this new data is the same as that originally reported in the SIGN guideline i.e. that cardiac rehabilitation is cost-effective. If the other parts of the guideline were being updated then the health economics section could be altered at that stage. There may also be other individual cost effectiveness analysis studies that have been published since 2002 that have not been picked up in the scoping search (I think that Rod Taylor published something recently on home versus hospital cardiac rehabilitation)</li> <li>▪ Not at this time. SIGN 57 was quite far reaching and talked about areas where there was little evidence e.g targeting therapy and using a menu-driven approach. These are still being implemented and it is probably too soon to evaluate</li> </ul>

evidence of the impact of SIGN 57. There isn't enough that is new to justify a review and what there is has been reasonably covered in the recent CHD guidelines.

- Since the last guideline there have been many studies on exercise that will impact on chapter 3. There are now more high risk patient groups involved in exercise based CR.
- As recommended

3 Please list any additions to the remit of the guideline that you think would be beneficial

- The recommendations on cardiac rehabilitation in the recently published NICE post MI guideline CG48 are in keeping with SIGN 57
- Affiliated Heart Groups – Greater emphasis is required on the role of patient-led support groups. These groups are beneficial to many thousands of cardiac patients and their partners and are leading the way in self-management of cardiac conditions. The ideal setting for the self-help group is as an option in the menu of cardiac rehab in each area. There are currently 35 cardiac support groups/clubs affiliated to CHSS, benefiting over 1500 people across Scotland; each group/club run by people with experience of heart disease. Each group/club has its own constitution, aims and objectives and is shaped by local requirements. Aims include ongoing rehabilitation, the emotional and social support of cardiac patients and carers, secondary prevention, information, signposting and education. These affiliated groups/clubs provide a wide range of activities and offer members, relatives and carers ongoing support, stimulation and companionship in a friendly and relaxed environment within the community. CHSS support these groups/clubs in maintaining high standards of operation, meeting health and safety requirements and serving the needs of the local population.  
Support for affiliated heart groups – CHSS Affiliated Groups have been endorsed by SIGN 95  
 There has also been a study conducted by the Research Unit in Health & Behaviour Change (RUBCH), University of Edinburgh, 2006; which found that ‘benefits to health included: the promotion of ‘moving on’ to live a full and active ‘normal’ life; access to a range of health and non-health related information; (in some groups) facilitated exercise that accommodated the needs and concerns of people with heart disease and a camaraderie that facilitated the monitoring of the health of other members.’  
 ‘social benefits included: meeting people (especially others with heart disease) and reducing isolation; and a sense of enjoyment and fun that motivated attendance and had a mood-boosting effect.’  
 Self-management is a key objective of Delivering for health and affiliated groups provide the ideal vehicle for encouraging self-management in a supportive environment.  
Angina Plan – needs to be discussion on this intervention within this guideline  
Smoking cessation – greater emphasis on the variety of options available and the importance of ensuring that the patient is directed to appropriate sources of support.  
Healthy Eating & Diet – again, more emphasis required on the importance of addressing dietary assessment and education. Discussion on the status of dietary supplements for clarification.
- More on exercise and behaviour strategies.

4 Please tick your preferred option for reviewing this guideline

a. there is no new evidence that will affect existing recommendations and the guideline should not be reviewed at this time	3
b. some recommendations will change in the light of the new evidence and selected elements of the guideline should be reviewed	2
c. the entire guideline should be reviewed	
d. the guideline should be withdrawn	

Thank you very much for taking part in this consultation.

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**Comments from Scottish Intercollegiate Guidelines Network Council meeting held 7<sup>th</sup> November 2007**

Defer review for a year and use CVD educational events as an opportunity for feedback.