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MEN'S PERCEPTION AFTER ACUTE MYOCARDIAL INFARCTION

Percepção de homens após infarto agudo do miocárdio

Percepción de los hombres después del infarto agudo de miocardio

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ABSTRACT

Objective: To understand men's perception about their feelings, repercussions of lifestyle change and family participation after acute myocardial infarction (AMI). **Methods:** Qualitative descriptive study conducted between March and June 2016 in Goiânia, Goiás, Brazil, using semi-structured interviews with adult men who had an episode of infarction. The analysis of the interviews was based on Grounded Theory, from which the following explanatory categories emerged: Feelings experienced by the patients after diagnosis of AMI; Repercussion of lifestyle change with focus on feeding and physical activity; Family involvement and support. **Results:** In the midst of the whirlwind of feelings that accompanied the diagnosis of AMI, the fear of finitude and of abandoning the family stood out. Lifestyle change, as an essential element of non-drug treatment, was initiated. However, with regard to feeding, they were partially insufficient due to the lack of adequate nutritional guidelines. As for physical activity, there was adequate awareness, but the difficulty of maintaining the new habit prevailed. Families have proved to be the main source of social support, being decisive in this process. The adherence was partial and the lack of continuity was the main obstacle. **Conclusion:** The success of continuous therapeutic planning depends on users' adherence, who experience difficulties in this aspect, even in the face of adequate social support. There is a clear need for raising awareness of secondary prevention and its benefits, of food education and of maintaining habit changes.

Descriptors: Lifestyle; Myocardial Infarction; Qualitative Research; Men's Health.

RESUMO

Objetivo: *Compreender a percepção de homens sobre seus próprios sentimentos, as repercussões das mudanças no estilo de vida e a participação familiar após infarto agudo do miocárdio (IAM).* ***Métodos:*** *Estudo descritivo com abordagem qualitativa, realizado entre março e junho de 2016, em Goiânia, Goiás, Brasil, no qual se aplicaram entrevistas semi-estruturadas a homens adultos que tiveram episódio de infarto. A análise das entrevistas se baseou na Teoria Fundamentada nos Dados (Grounded Theory), de onde emergiram as categorias explicativas: Sentimentos vivenciados pelos pacientes após diagnóstico de IAM; Repercussão da mudança no estilo de vida com enfoque na alimentação e atividade física; Envolvimento e suporte familiar.* ***Resultados:*** *Em meio aos diversos sentimentos que acompanham o diagnóstico de IAM, destacaram-se o medo da finitude e de desamparar a família. As mudanças no estilo de vida, como elemento essencial do tratamento não medicamentoso, eram iniciadas. Quanto à alimentação, porém, foram insuficientes, em parte, devido à falta de orientações nutricionais adequadas. No que se refere à prática de atividade física, havia conscientização adequada, mas prevaleceu a dificuldade de manutenção do novo hábito. As famílias se revelaram a fonte majoritária de apoio social, sendo decisivas nesse processo. A adesão demonstrou-se parcial, tendo a falta de continuidade como entrave principal.* ***Conclusão:*** *O sucesso do planejamento terapêutico contínuo depende da adesão dos usuários, com existência de dificuldades nesse aspecto, mesmo com suporte social adequado. Torna-se clara a necessidade da conscientização sobre prevenção secundária e seus benefícios, de educação alimentar e da manutenção da mudança de hábitos.*

Descritores*: Estilo de Vida; Infarto do Miocárdio; Pesquisa Qualitativa; Saúde do Homem.*

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RESUMEN

Objetivo: *Comprender la percepción de los hombres sobre sus propios sentimientos, las repercusiones de los cambios del estilo de vida y la participación familiar después del infarto agudo de miocardio (IAM).* ***Métodos:*** *Estudio descriptivo de abordaje cualitativo realizado entre marzo y junio de 2016 en Goiânia, Goiás, Brasil en el cual se aplicaron entrevistas semi-estructuradas a los hombres adultos que tuvieron algún episodio de infarto. El análisis de las entrevistas se dio a través de la Teoría Fundamentada de los Datos (Grounded Theory) de lo cual emergieron las categorías explicativas: Sentimientos vividos por los pacientes después del diagnóstico de IAM; Repercusión del cambio del estilo de vida basado en la alimentación y actividad física; Envolvimiento y apoyo familiar.* ***Resultados:*** *Entre los diversos sentimientos que acompañan el diagnóstico de IAM se destacaron el miedo de la finitud y de abandonar a la familia. Se iniciaban los cambios del estilo de vida como elemento esencial del tratamiento sin medicación. Sin embargo, los cambios respecto la alimentación fueron insuficientes, en parte, debido la falta de orientaciones nutricionales adecuadas. Había concienciación adecuada sobre la práctica de actividad física pero prevaleció la dificultad para la manutención del nuevo hábito. Las familias se revelaron la principal fuente de apoyo social, siendo decisivas en el proceso. La adhesión ha sido parcial y la falta de seguimiento ha sido la principal traba.* ***Conclusión:*** *El éxito del planeamiento terapéutico continuo depende de la adhesión de los usuarios, con dificultades en ese aspecto, aunque con apoyo adecuado. Es evidente la necesidad de la concienciación de la prevención secundaria y sus beneficios, de la educación alimentaria y de la manutención de los cambios de hábitos. .*

Descriptores*: Estilo de Vida; Infarto del Miocardio; Investigación Cualitativa; Salud del Hombre.*

INTRODUCTION

Cardiovascular diseases (CVD) are the leading cause of death worldwide, and in Brazil it accounts for 30% of deaths[1]. According to data from the Department of Informatics of the Unified Health System (*Departamento de Informática do Sistema* Único *de Saúde – DATASUS*), 28% of the 1,210,474 deaths that occurred in Brazil in 2013 were caused by circulatory system diseases. In addition, circulatory diseases accounted for 10.12% of all hospitalizations, leading to a high hospital spending[2].

One of these diseases is the acute myocardial infarction (AMI), which is the term used classically for the area of ischemic necrosis of a portion of the heart muscle caused by acute occlusion of the epicardial coronary arteries. It is, in about 90% of cases, the clinical expression of the instability of a coronary atherosclerotic plaque with formation of obstructive thrombus[3]. Its risk factors fall into two categories: non-modifiable factors, which include age, gender, and heredity; and modifiable factors, which are acquired over the years and are related to lifestyle, such as: hypertension, smoking, dyslipidemia, obesity, sedentary lifestyle, diabetes mellitus[4].

In recent years, much effort has been made to achieve progressively greater efficacy in the treatment of AMI. To reduce public health costs[5], which are quite high[6], investments must be made in primary prevention (focused on risk factors)[7] and secondary prevention (treating the disease adequately to reduce the rate of recurrence)[6,7]. Secondary prevention is based on the correct use of prescribed medications and lifestyle changes. Its importance lies in its ability to mitigate the risk of new episodes of AMI[8].

CVDs are expected to increase disability life-adjusted years (DALY) from 85 million to 150 million worldwide by 2020, leading to a decrease in global productivity[1].

Lifestyle change is a key point in the non-drug therapy of these patients[9]. It is at least as effective as drug therapy[7] and it may be consist of regular physical activity and modification of eating habits. The cardioprotective effect of regular physical exercise makes it indispensable as a secondary prevention resource[8,10].

Given that, the present research focuses on the occurrence of this problem in men, since this population group is more frequently ill and more susceptible to preventable diseases[11] when compared with women of reproductive age[12,13]. Therefore, the present study is relevant because it offers the opportunity to deepen the knowledge about men's perceptions after AMI, which allows a better understanding of the difficulties faced with a view to improving the quality of the therapeutic follow-up and the health promotion in this population.

Thus, the present article focused on the perspective of men who had an episode of AMI and aimed to understand men's perception about their feelings, repercussions of lifestyle change and family participation after acute myocardial infarction.

METHODS

This is a qualitative descriptive study. This type of study involves a set of memories, beliefs, values, ambitions and attitudes and addresses a more intimate plane of relationships and phenomena that cannot be limited to the superficiality of numerical objectivity[14]. It also aims to provide more information and data on the theme addressed, allowing a better understanding of the demarcation of the subject analyzed[15].

The empirical study was conducted with data collected in the Cardiology Department of the Santa Casa de Misericórdia Teaching Hospital in Goiânia, Goiás, Brazil[16]. The interviewees were selected from records of the medical and statistical filing system (*Serviço de Arquivo Médico e Estatístico – SAME*) of the hospital. Adult male patients diagnosed with AMI by a physician for more than one year living in the urban area of Goiânia, Goiás, were included. Patients who did not regularly attend the cardiology service and those with cognitive deficits were not included.

The selection of men for the interview was carried out through a survey and analysis of 73 medical records dating from 2013 to 2015. After the analysis, 19 participants who met the inclusion criteria were selected. All the selected participants were contacted via telephone to explain the research objectives and schedule the interviews. Of this total, eight agreed to be interviewed. The interviews were carried out face to face in an environment where only the researcher and the participant were present.

The interview was semi-structured. Such social research technique allowed the interviewee to answer – based on his ideas – questions from a previously designed questionnaire without the researcher ceasing to act in the process of information collection. The questionnaire comprised data on the identification of the participants (current age, age in the episode of AMI, marital status, children, education, professional activity) and guiding themes that helped the interviewer to maintain the focus on the research objective and guide the flow of ideas of the interviewee[17]. The themes were: life habits before the episode of AMI; perception of the AMI episode itself; post-episode therapeutic procedures; non-drug therapy; strategies and difficulties to maintain treatment; family involvement; impact of non-drug therapy.

The interviews lasted an average of 40 minutes and were carried out between March and June 2016. To ensure the anonymity of the participants, all interviews were coded and the real names were replaced with the letter "P", which refers to the term "participant".

The analysis of the interviews was based on the perspective of Grounded Theory, an inductive methodology that, without starting from previously established theories, approaches the study object, allowing the formulation of a theory from the systematic collection and analysis of data[18]. The discourses were coded, which corresponded to the meticulous analysis of the data, and the findings of the several elements studied were compared in order to formulate explanatory theories about the phenomena studied based on three different stages: open, axial and selective coding[18].

In open coding, the researchers defined, categorized, and compared the data. Then, in the axial coding, the most important or central categories were differentiated from the subcategories, searching for connections between them. The last stage, called selective coding, consisted of "a descriptive narrative of the central phenomenon of the study", synthesizing everything that was obtained in data collection and coding and explaining the differences and similarities found[18].

After carrying out and analyzing the interviews, with subsequent coding of the interviewees' discourses, the following categories emerged: Feelings experienced by the patients after the diagnosis of AMI; Repercussion of lifestyle change with a focus on diet and physical activity; Family involvement and support.

The present study was approved by the Research Ethics Committee of the Pontifical Catholic University of Goiás under Approval No. 1.420.006 and by the Research Ethics Committee of the Goiânia Santa Casa de Misericórdia Hospital under Approval No. 1.460.345.

RESULTS AND DISCUSSION

The data on the identification of the eight interviewees are presented below. Then, the description and discussion of the explanatory categories that emerged from the coding of the interviewees' discourses are presented.

Interviwees' identification data

The mean age of the participants is 58 years, and the AMI episode occurred at the man age of 50.5 years. All the participants were married and had more than one child; in addition, most of them had incomplete elementary education and had different jobs.

Feelings experienced after the diagnosis of AMI

This category, which emerged from the discourses, addresses men's perception of the disease, the fear of death, and their concern for loved ones. It was thus observed that AMI suddenly sets in and determines difficult and painful changes in the health status of an individual who did not expect to become ill or have his life changed due to illness. The intense sensory overload imposed on the individual when he is having an infarct triggers emotional conflicts.

> *"I was worried because I did not know what it was." (P4)*
> *"Oh! It is a desperate situation." (P5)*
> *"I got very nervous at the time because I knew it was a critical situation." (P8)*

The genesis of the afflictions reported by many interviewees is multifactorial, and it is possible to catalog the main concerns that permeate their consciousness. Fear of the possibility of death is frequently present in their statements, as demonstrated below:

> *"It was such a desperation. I thought I was going to die." (P1)*
>
> *"At the time, I was afraid to die. The pain was suffocating me. I did not know what was going to happen." (P5)*
>
> *"I was desperate. I thought death would come and get me." (P6)*

The literature has already demonstrated that the disease is a source of repulsion and synthesizes what tends to be the most terrible thing in human existence: death. Behind so much anguish, there is the symbolism of such a vital organ, namely the heart, which is the maintainer of life. Any problem that affects it is felt as a threat to life, justifying this fear of death[19].

Although the instinct for the preservation or expansion of life was being confronted by infarction, for some participants the source of negative feelings was not the fear of death, but the aversion to the helplessness that its absence could impose on those who would stay alive, especially their children.

> *"I thought of everything. Family, children. At that time, my daughters were still very young; one was 8 and the other was 12 years old. It was a desperate situation." (P1)*
>
> *"I was 38 and had two young children. My daughter is 4 years old now. At that time, my son was 9 years old. So, we were desperate, do you get it?" (P5)*

Uncertainty about the prognosis, doubt about the possibility of treatment and the need for therapeutic procedures led to the greater occurrence of feelings of anxiety in men. Thus, not only the fear of death, but also the knowledge of the complications of the diagnostic tests, the expectation of the diagnosis and the hospitalization contribute to the increased occurrence of anxious symptoms, fears and other psychological repercussions that can even aggravate the clinical picture[20].

For some interviewees, fear and anxiety were directed at the therapy that would be established for the resolution of the excruciating symptoms and the disease. For one of the participants, the emotional conflicts originated from ignorance of possible procedures after infarction.

> *"I just wanted to get rid of the pain, but I did not know how or what was the procedure that was going to undergo. Because I have never been through this, I have never seen a similar case. I have seen people fall and die. But in my case, I did not know what was going to happen." (P4)*

For another interviewee, knowing the reperfusion strategy that would be adopted did not deprive him of his afflictions.

> *"I was scared to death. Especially when they said they would cut me." (P6)*

In contrast, some reports have shown that acute myocardial infarction did not really trigger emotional shock. A less catastrophic assimilation of the episode is possible, as it is shown in following statements:

> *"Look, I was not even scared or shocked. I did not think much." (P7)*
>
> *"But for me it was easy to get the diagnosis of AMI. After I found out, I kept waiting to be transferred from the Health Care Center to the hospital. I kept calm." (P3)*

Patients with cardiovascular diseases must have a break from everyday life and often from work obligations and abandon old habits in order to exclude or control risk factors[21].

Lifestyle change with a focus on diet and physical activity

This explanatory category describes the difficulties that AMI poses to the life of the men interviewed. Lifestyle change is the cornerstone of secondary prevention of AMI. The need for smoking cessation, sedentary lifestyle abandonment, weight loss, adoption of a balanced diet, treatment of hypertension and diabetes mellitus and dyslipidemia are always approached by the health professional who preserves good practices. It is clear, however, that the statements and concerns are predominantly permeated with the need to engage into regular physical exercises and adopt a healthy diet.

With regard to eating habits prior to coronary disease, some aspects repeated in the statements should be highlighted. One of the main aspects was the presence of copious meals with high lipid content.

> *"I used to eat fatty meat prepared on pork butter. I did not follow a diet plan. The fatter the meat, the more I liked it." (P2)*
>
> *"I used to eat pork, the one with the thick butter." (P6)*
>
> *"I used to like very fatty meat; I used to eat the fat of the meat." (P8)*

In view of the increased prevalence of cardiovascular diseases, there should be a growing demand for nutrition counseling. Such knowledge, although not enough to change behaviors, is crucial for people to acquire autonomy for conscious decision-

making regarding their real health status[21]. The interviewees' discourses on therapeutic dietary changes after AMI demonstrated some knowledge of the need for a change in diet.

Another very clear issue present in the interviewees' statements was the absence of vegetables, legumes and fruits in their daily diet. However, after being diagnosed and counselled, patients moved from the pre-contemplation stage, which is understood as the lack of intention to change, to the action stage. The hegemonic aspect found in the statements was an effort directed basically towards the adoption of a hypolipidemic diet low in sodium.

Studies have identified many dietary patterns that have been proven to reduce cardiovascular risk, including: the Mediterranean Diet, the Paleolithic Diet, the Dietary Approaches to Stop Hypertension (DASH), the Vegan Diet, the Okinawa Diet and the Southwest Asia Diet[22-24]. However, rather than determining the most effective dietary pattern for the prevention and management of cardiovascular diseases focusing on the individual characteristics of each diet, one should focus on the elements shared between them[22].

In this regard, several aspects could be listed as hypotheses for the difficulties in accepting changes in diet, mainly the the discipline required to change already established habits.

> *"It is difficult because once you get used to eating strong food for a lifetime, it gets hard to change, but that is going to be over." (P1)*
>
> *"It is hard to change a habit, isn't it? You must have a lot of discipline. Quitting what you like is difficult." (P5)*

On the other hand, there are individuals who, in moments of crucial need for change, exert all their mental strength for that purpose, preferring health gains over culturally appreciated life habits.

Compatible items in the dietary models can be summarized in the following dietary goals: consuming more fruits, vegetables, whole grains, soluble fiber, vegetables, lean meat, nuts, skimmed milk, soy and soy proteins; and consuming less fried foods, meat, processed meat, sugary drinks, and trans and saturated fat. And finally, the main rule is: prefer small portions over copious portions[4,22-24].

The content of the interviewees' discourses showed that the changes are far from those proposed by several studies. Men are basically concerned with reducing their consumption of fried foods and salt and the use of pork fat and preferring lean meat and increasing consumption of fruits and vegetables. Patients were not aware of other important components of a diet after AMI. Ensuring that people understand the relationship between behavior, health and illness, engaging them in their treatment and educating them on the ideal dietary pattern are imperative for the development of an engaged consciousness and a proactive individual[21].

Regarding regular physical activity before AMI, a large part of the patients had never practiced physical exercises, or exercised on an irregular basis. When questioned about the reason for this behavior, several interviewees blamed their work routine.

> *"I did not practice physical exercises regularly because I worked hard." (P2)*
>
> *"The rush at work and everyday life kept me from doing it." (P7)*

On the other hand, other participants recognized the importance of physical activity and even began to practice some sport, but failed to remain motivated.

> *"I went to the cardiologist and he asked me to jog, but I had stopped jogging long before the heart attack." (P4)*

AMI, after the resolution of its acute and critical phase, demands chronic and permanent care, which is based on two main strands: drug therapy and non-drug therapy. Non-drug therapy is at least as effective as the use of medications[7]. One of the main aspects of this treatment is regular physical exercise, which is an indispensable element in cardiac rehabilitation after an ischemic event[25].

It should be noted that the shocking diagnosis of AMI caused behavior changes in mend and led most of the interviewees to actively engage in the eradication of sedentary lifestyle.

> *"I do it (jogging) every day, from Monday to Friday." (P2)*
>
> *"I jog around 45-60 minutes every day." (P1)*
>
> *"I have been jogging for two years now, Monday through Friday." (P8)*

On the other hand, some of the interviewees maintained a sedentary behavior. Not even the recently experienced coronary disease was able to cause habit changes. Some interviewees engaged into sporadic physical activity only, and others did not even begin the process of acquiring new habits.

> *"Jogging makes me feel lighter, more agile. If I spend two days without jogging, I can already feel the difference. These changes contribute to my well-being." (P1)*
>
> *"I feel better. My breathing is different, my mood is different. I have been more cheerful." (P4)*
>
> *"When I changed my habits, I felt very well. I slept better, I was less nervous and anxious, and more cheerful." (P5)*
>
> *"I feel a little better." (P7)*

The counseling received during hospitalization and follow-up consultations corroborate the fact that a physical exercise program, as a form of cardiac rehabilitation, should be offered to all coronary patients, showing the benefits of engaging in physical activity[26,27].

The interviewees said they were told to start jogging lightly and then increase their pace and intensity. Studies have identified a correct emphasis on physical exercise after AMI[28] and recommended the beginning of a supervised physical exercise program about one week[29] to ten days after hospital discharge, starting with 20-30 minutes daily at a comfortable level and increasing the intensity during the improvement of physical and cardiovascular fitness[26,30].

Not only subjective aspects have been affected by the changes made, but also physiological parameters objectively monitored by the physicians, such as systemic blood pressure. Another essential parameter mentioned was the systemic level of cholesterol. Finally, the central motivation for all the treatment and follow-up and for each painful change made by the interviewees could not fail to be noticed in the interviews.

When asked about the improvements in well-being and quality of life, the interviewees who engaged in regular physical activity recognized the benefits of exercising. This finding is consistent with studies that have highlighted positive results from a balanced physical activity program. Some the benefits included: increased life expectancy, prevention of cardiac events, improvement of cardiac function and cardiac remodeling, and reduction of atherosclerotic plaques[28]; modification of cardiovascular risk factors and reduction of resting heart rate[31]; reduction of morbidity and mortality, with an increase in quality of life[29]; decreased stress-induced ischemia and increased cardiovascular capacity[32]; reduction of late coronary restenosis[33]; reduction of disease progression and a positive influence on coronary endothelial function[34]; and reduction of hospitalizations[35].

Family involvement and support

This explanatory category focuses on family participation in the process of understanding the disease and co-participation in lifestyle changes. The interviews clearly demonstrated the influence and support of family members in food reeducation and changes in family dynamics after post-infarction medical guidelines.

> *"Everyone eventually changed, and they even got used to it." (P2)*
>
> *"The diet of the entire family changed. Everyone is looking for a healthier diet." (P3)*
>
> *"Everyone has changed something, and they will change more now." (P6)*

When reporting the changes in the family's diet, all the interviewees invariably stated that only one type of food was prepared in their homes, i.e., there were no chances of preparing a separate food for them while their families maintained their previous eating habits. Therefore, everyone was affected by the changes made.

One of the factors associated with successful non-drug therapy was family support. During the recovery of AMI, individuals need help with their psychosocial condition[36]. The family becomes the most important social support network[37]. The interviews showed that a single type of food was prepared, so the whole family had to adapt to the patient's dietary needs. Family members agreed to do so because they understood the problem and were aware of the importance of such changes. These findings corroborate the high level of family support, with a prevalence of an effective support[38,39].

Positive support from the family, especially the wife, is clear in the statements. The family plays a key role in making the necessary dietary changes and encouraging the interviewees to properly follow the medical guidelines. Importantly, two interviewees reported that the family members responsible for inspecting and ensuring compliance with the medical guidelines were their daughters, both of whom were nutritionists.

When asked about the possibility of difficult acceptance of the new diet by the family members, the interviewees reported some complaints in some cases; however, they managed to work them out through dialogue and awareness.

> *"Sometimes my son even complains about the food, saying that it lacks salt, but my wife says that since I had the AMI the food had to be changed because of me. He understands it". (P2)*

An interesting fact noted in the interviews is that most families provide support, participate and encourage the interviewees to comply with the food guidelines. However, few family members engaged into regular physical activity. Some wives and children changed their physical activity patterns after witnessing the suffering caused by the disease of the interviewee.

Despite all social and family support, patients who have experienced a serious disease, such as AMI, often have difficulties in adhering to or maintaining treatment. In order to be effective, the non-drug therapy after infarction should become a priority in patients' lives[10].

The fundamental importance of adhering to a lifestyle change lies in the lower rates of cardiovascular disease and mortality after changes in unhealthy habits[8]. Therefore, lifestyle changes should be encouraged in spite of the difficulties faced for its long-term continuity, not only for reducing the recurrence of AMI episodes, but also for improving patients' quality of life[9,10].

Studies have shown that properly informed coronary patients tend to adopt a proactive approach and develop self-care[10,21]. Due to the life threat in the acute phase of the disease, several patients decide to change their lifestyle; however, after stabilizing the condition, they find it difficult to stand firm, which shows that the great challenge is to continue what has been started[40].

There are still divergent results in the literature about the levels of treatment adherence in the general population. Some findings show that a large number of patients adhere to the treatment[10] and other results point to a low adherence by patients, with a third of them not effectively adhering to prevention[7]. Even those who adhere to the recommendations fail to achieve therapeutic goals[41].

Therefore, patients' main difficulties may be related to the lack of understanding/acceptance of an AMI long-term treatment and continuous adherence to the treatment. Failure to follow the proposed treatment may lead to potential complications in the future, such as the increase in the number of recurrences of the disease, culminating in an increase in the mortality of adult men[40]. Thus, these patients should be sensitized by the health team to increase the quality of life and improve health conditions.

The interviews portrayed well the perception and experience of the health problem. By demonstrating the feelings experienced during AMI episodes, the importance of changing lifestyle and the difficulties in making and maintaining such changes, the immeasurable relevance of family support and the essential paradigms of adherence to treatment, the present study sought to contribute to the understanding of this disease that as a great impact on the Brazilian public health.

FINAL CONSIDERATIONS

The confirmation of a serious disease triggers feelings that denote suffering. Upon receiving the diagnosis of AMI, the adult man experiences uncertainty about the prognosis, doubts about the possibility of treatment and the need for therapeutic procedures, and the fear of failure to assist dependent family members. Among so many feelings, the fear of finitude prevails.

After the diagnosis, there were changes of attitudes related to the diet, but they were still insufficient as an effective measure of control of the risk factors. The statements demonstrate the lack of information on all the food components that make up a salutary diet. Regarding regular physical exercises, the interviews showed that men were aware and informed about the need to change such aspect, but they did not always engage in long-term physical activity.

The complex changes and challenges arising from the experience of AMI, its treatment and follow-up, strongly affect patients' families. Further, the family is the major source of social support to cope with the disease and it helps the patient overcome and move forward, with a direct and decisive impact on lifestyle change.

The success of therapeutic planning depends on patient adherence to the proposed treatment. The present study demonstrated the existence of difficulties in this aspect, even in the face of adequate social support. There is a clear need for awareness of the chronic nature of secondary prevention and its benefits and food education with a special focus on lifestyle change and maintenance of such changes, which constitute the main obstacles to a better quality of life.

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