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Commentary

Comprehensive Care for Adults with Congenital Heart Disease

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DESCRIPTION

Adults with congenital cardiac disease are becoming increasingly common. Despite the fact that these patients' life expectancy is improving, they may face distinct medical, psychological, and behavioral issues throughout their lives. Patients' sickness experiences, knowledge and health behavior, employability and insurability all require special care. As a result, comprehensive care from specialized health care specialists is essential, addressing the patients' complex concerns. Nurse-led interdisciplinary teams that ensure management beyond usual medical conditions are promising. Facilitation of the transition from pediatric to adult cardiology, identification of patient requirements, screening and referral for psychosocial difficulties, and patient and family education and counseling are all important aspects of nurses' involvement. An advanced practice nurse, in particular, appears to be essential for optimizing illness care of adult patients with congenital heart disease. What exactly do we mean when we say comprehensive care "Including or dealing with all or nearly all of the important components or features," according to the Oxford English dictionary. Another term for comprehensive care is holistic approach, which means 'all, complete, full, total.' The sum of something's pieces is far more than the sum of its parts, and they can't be grasped by looking at them separately.

Some of the adult patient's healthcare demands will eventually fall to caregivers who have little or no specific expertise in Congenital Heart Disease (CHD). Adult CHD patients have been classified as having highly complicated, moderately severe, or less severe problems. Depending on the severity of the underlying ailment and the health issue at hand, the extent to which the patient's treatment is managed by a highly competent team at a regional centre with specialized knowledge will vary. Although regional centres of excellence may play a role in the most complicated situations, these patients will face common adult illnesses, which will be the responsibility of the local physician. 45 percent of adult CHD patients may not require routine follow-up at a specialist facility, according to estimates. The primary care practitioner will be asked to play a significant role in the patient's health maintenance and the management of coexisting illnesses and disorders. These health problems may be caused by the underlying CHD or unrelated comorbidities that are likely to develop, the treatment of which may or may not be affected by the patient's heart condition.

Many CHD patients can live into maturity and lead active lives thanks to surgical and/or catheter-based therapies. Patients may endure residua or squeal of their initial treatment, despite these breakthroughs in therapy: congenital heart abnormalities are regarded repaired rather than healed. As a result, patient treatment for congenital heart disease involves lifelong monitoring. By definition, adult congenital cardiology encompasses individuals with complicated anatomy and pathophysiology. Many CHD patients suffer from problems that affect organs other than the cardiovascular system, which is known as a multisystem disease. Adults with CHD often have pulmonary arterial hypertension, renal failure, and anemia, which are all indicators of a bad prognosis.

Physicians should be aware that Adult Congenital Heart Disease (ACHD) patients may require psychosocial assistance in addition to medical treatment. Patients have lived their whole lives with a chronic heart ailment that necessitates frequent clinical evaluations, invasive investigations, and procedures. While we don't want to minimize our patients' incredible strength and perseverance, we should be mindful that people with CHD have a higher rate of anxiety. Despite significant advances in life expectancy in patients with CHD, the average age of death is still younger than in those with acquired heart disease, with circulatory failure being the predominant cause of death. Despite this, there is a scarcity of information about end-of-life discussions and treatment in this patient group. It is incredibly distressing for both the family and the health care professionals when a child dies.

For a non-expert doctor, exercise prescription will be a difficult task. The 26th Bethesda Conference provided the most widely utilized guidelines in this area. It is yet unknown if physical training increases exercise tolerance, quality of life, or length of life in persons with CHD. One can only hope that the beneficial benefits shown in patients with coronary artery disease and

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congestive heart failure will be extended to this group. From the standpoint of health maintenance and primary coronary risk reduction, the patient's comprehension of the need of a routine exercise program within the constraints of his or her condition is crucial.