

LIVING WITH CORONARY HEART DISEASE: UNDERSTANDING, PREVENTION AND EFFECTIVE MANAGEMENT

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Introduction

Coronary heart disease (CHD) is among the major health issues leading to mortality and it is still a challenge for public health globally (Vaduganathan *et al.* 2022). This condition arises due to accumulation of fat that causes coronary arteries to become constricted, which hinders supply of blood to heart (Shahjehan *et al.* 2024). Globally, around 9 million deaths occur yearly due to ischaemic heart disease, which continues to be the main cause of death (Okorigba *et al.* 2026). Within UK, CHD stands as premature cause of death at younger age, where

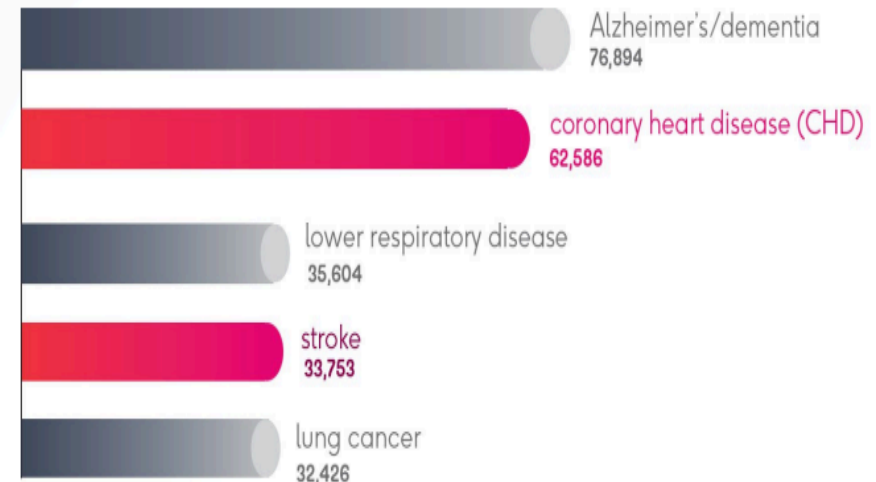


(Source: WHO, 2024)

over 100,000 heart attack-related hospital admissions occur every year (British Heart Foundation, 2026). More than 1.4 million people in UK are survived after a heart attack, which shows that survival rates have improved; however, there is a

(Source: British Heart Foundation, 2026)

Top Five Single Biggest Killers in the UK, 2024

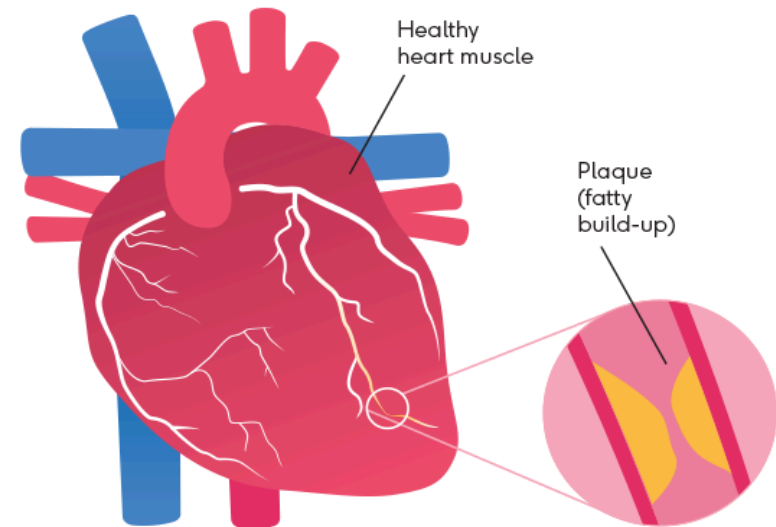


rising need for long-term care. Heart and circulatory diseases result in NHS spending billions of pounds every year. Therefore, management of risk factors that can be controlled

and encouraging early diagnosis are two key aspects in lessening chances of complications, enhancing quality of life, and reducing burden on healthcare services in long term.

Definition

Coronary heart disease (CHD) is the result of a build-up of fatty plaques inside coronary arteries, supplying oxygen-rich blood to heart muscle. The plaques limit blood flow; therefore, decrease amount of oxygen delivered to the heart (NHLBI, 2024). A reduction in blood flow to the heart first leads to stable angina, when chest pain is experienced during physical exertion and relieved by rest. If a plaque ruptures, a blood clot can form and a partial or total blockage of coronary artery will cause acute coronary syndrome (Malik *et al.* 2023). If blood supply is totally cut off, heart muscle will start to die, which is called a myocardial infarction or heart attack. Approximately 2.3 million people in England have CHD; therefore, it is crucial to understand how the disease develops and to take therapeutic measures promptly for avoiding fatal damage to the heart (BHF, 2024).



(Source: BHF, 2024)

Signs and symptoms

CHD symptoms arise when heart muscle does not get enough oxygen due to limited blood flow because of narrowing of coronary arteries (Mahmuda *et al.* 2021). Identifying the problems at an early stage enhances effectiveness of treatment and diminishes risk of severe complications. It is estimated that in UK, up to 80% of premature heart disease incidents are related to risk factors that could have been prevented (UK Health Security Agency, 2018). Therefore,

recognising early signs and symptoms of the disease is a priority.

Common signs and symptoms are: chest pain or tightness (angina), shortness of breath, fatigue, dizziness or light-headedness, cold sweating, pain spreading to the left arm, shoulder, neck or jaw, and nausea or indigestion-like discomfort (NHS UK, 2026)

Emotional and psychological symptoms are: anxiety, fear of another heart attack, depression, reduced confidence, ongoing stress.

Symptoms can differ in severity and frequency. Older adults, females, and individuals with diabetes may have fewer common symptoms, which resulted as delayed diagnosis. Certain people possess silent coronary heart disease, demonstrating very little or no symptoms at all until a major cardiac event, such as a heart attack, takes place (Theofilis *et al.* 2024). Evaluating unusual symptoms at an early stage can greatly enhance long-term results.

Burden and prevalence of long-term conditions (Worldwide)

CHD is still the main cause of cardiovascular disease worldwide. As per WHO, (2024), ischaemic heart disease was responsible for about 13% of total deaths globally in 2021. Besides this, many people live with a long-term disability, which is estimated by disability-adjusted life years (DALYs).

Burden and prevalence of long-term conditions (UK statistics)

In UK, CHD affects approximately 2.3 million people among which 1.5 million are men and about 830,000 are women (BHF, 2024). Moreover, CHD is less likely to be found in young adults, and risk increases significantly with age, especially after 65 years of age (Meirhaeghe *et al.* 2020).

Deprived communities and individuals of South Asian origin suffer extensively due to their greater exposure to cardiovascular risk factors (Anand *et al.* 2025). Additionally, geographical disparities are evident as the highest incidence is seen in North West England, while southern areas have the

least. Better emergency care and secondary prevention have produced a rise in survival, leading to higher demand for long-term care services. The above factors indicate that ageing, unhealthy lifestyles, socioeconomic disparities, ethnicity, and improved survival rates together determine ongoing problem of CHD; thus, demanding well-focused preventive measures and fair access to healthcare throughout UK.

Risk factors and aetiology of CHD

CHD develops with a combination of factors like biological factors, lifestyle, medical, and social factors.

Biological risk factors are aging, genetic makeup, gender specification (predominant among male), and South Asian ethnic group, which increase risk of cardiovascular disease (Goyal, and Sanghera, 2021). Major changes in **lifestyle** gave a significant impact. Smoking can lead to destruction of the walls of blood vessels (Ishida *et al.* 2024). Not having a healthy diet causes an increase in cholesterol level. Obesity imposes greater strain on health muscles to function properly. Lack of physical activity will lead to cardiovascular destruction

(Barbalho *et al.* 2020). Alcohol in excessive amounts causes an increase in blood pressure. Chronic stress leads to unhealthy behaviours.

Medical risk factors, such as high blood pressure, diabetes, hyperlipidaemia, and chronic kidney disease lead to an increase in atherosclerosis; thereby, increase risk of heart attacks. In England, nearly 30% of adult population has hypertension and over 5.8 million people have diabetes, which is a major cause of cardiovascular risk (The Guardian, 2025).

Social determinants of health play a role in disease development. Poverty, low level of education, improper housing conditions, lack of accessibility to healthcare, unemployment, and unhealthy food environments limit possibilities of healthy living and early prevention (WHO, 2026).

Hence, CHD should not be treated solely as result of individual lifestyle decisions. Genetic predisposition continuously interacts with environmental and social factors of surroundings throughout life. Those who are exposed to several disadvantages have higher cumulative risk, which

emphasizes importance of prevention measures that encompass personal behaviour change, public health and policy interventions.

Impact of CHD

Physical implications

Physical symptoms that result from this can be angina, heart attacks, fatigue, breathlessness, decreased mobility, heart failure, induced stroke risk, and long-term disability. These issues usually restrict leaving the house, working, and doing daily tasks. Around 920,000 people in UK are living with heart failure, and CHD is still a major cause (NHS UK, 2026). So, when the illness gets worse, there is more reliance on health and social care services.

Psychological implications

Psychological effects may involve anxiety, depression, a fear of experiencing another cardiac episode, decreased self-confidence, loss of personal freedom, and lower quality of life (Murphy *et al.* 2022). Depression has been found to correlate with non-compliance with medication, lesser

involvement in cardiac rehabilitation, and a substandard recovery. All these factors collectively result in deteriorated cardiovascular outcomes.

Social implications

Social implications are decreased opportunities of employment, financial hardships, limitations in driving, lesser physical activities, relationship tensions, and social isolation.

Wider implications on families

To provide for long-term care, **families and carers** undergoing emotional stress, physical strain, lifestyle changes, and caregiver burnout. Caring duties may have an impact on one's job and well-being.

Collectively, these effects define that CHD is not merely a physical ailment. Patient and family-centred interventions, psychological support, team rehabilitation, and community services generally are extremely necessary to enhance recovery, increase self-management, lessen caregiver burden, and improve lifestyle and long-term quality of life for both patients and families.

Prevention of CHD

Primary prevention (Preventing CHD before it develops)

Primary prevention includes preventive measures for CHD from even happening. This should focus on diets full of fruits and vegetables and low in saturated fat and salt, maintaining a healthy body weight, exercising at least 150 minutes weekly, giving up smoking, moderating alcohol consumption, controlling blood pressure (CDC, 2026). All these measures significantly reduce risk for cardiovascular disease. **NHS Health Check programme in England** offers adults between 40-74 years of age an opportunity to find preventable risk factors (NHS UK, 2026). Healthy lifestyle promotion through local initiatives also supports behavioural changes that last longer and reduce chances of getting a disease in future.

Secondary prevention (Early detection and risk reduction)

Secondary prevention targets identifying individuals at high risk, who can then be intervened before they get serious complications. Medical professionals assess risk levels

through using QRISK3 assessments, blood pressure monitoring, cholesterol testing, diabetes screening, and regular cardiovascular reviews, which allow them to estimate likely development of a problem and determine the most suitable treatment for patient (Jain *et al.* 2024). Detecting the disease at early-onset enhances timely lifestyle modifications and use of preventive medicine which could greatly reduce progression of CHD.

Tertiary prevention (Preventing further complications)

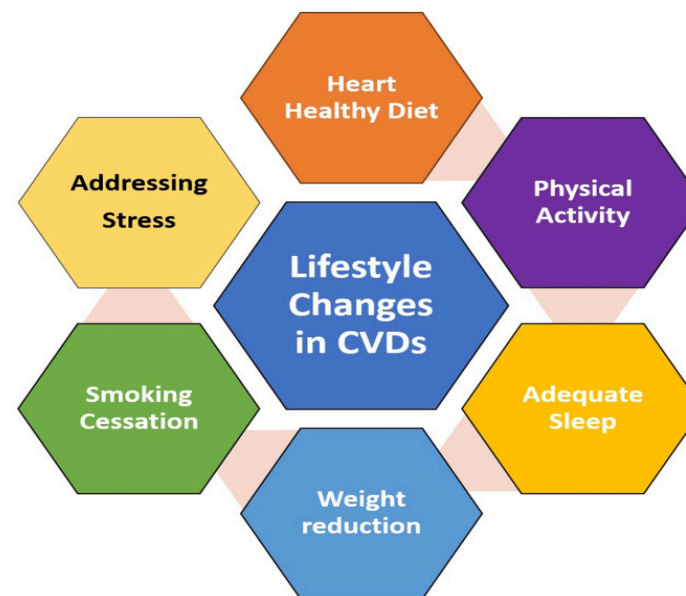
Tertiary prevention aims to support to patients, who already have been diagnosed with CHD. Cardiac rehabilitation is a combination of training under a doctor's supervision, teaching, psychological help, and lifestyle counselling based on recovery measurements after cardiac events (Zaree *et al.* 2023). Taking medicine properly, lowering cholesterol, and controlling blood pressure with medicines, having follow-up appointments regularly, and monitoring up-to-date are preventive measures to reduce recurrent heart attacks and hospital admission rates. Collaboration between individuals, families, healthcare professionals, and public health services

is key to effective prevention. Healthy habits combined with deliverable NHS interventions offer the largest chance for reduction in development of long-term complications, enhancement of quality of life, and decrease in burden on healthcare resources throughout UK.

Evidence-based treatments available through NHS

Lifestyle interventions

According to NHS recommendations (2024), lifestyle modifications should be the initial step in managing CHD. The patient must engage in physical activities regularly, adopt a heart-friendly diet guided by a nutritionist, quit smoking, lose excess body weight, and endure cardiac rehabilitation, which will enhance their heart performance and lower further cardiovascular risks (Ghodeshwar *et al.* 2023). Cardiac rehabilitation programs in NHS incorporate exercise, education, and psychosocial interventions for long-term recovery.



(Source: Ghodeshwar *et al.* 2023)

Medical management

Drugs aid in symptom relief and preventing complications. **Statins** are used for lowering cholesterol level, whereas **aspirin** along with other antiplatelet drugs help in avoiding clot formation of blood (Nenna *et al.* 2021). **ACE inhibitors, beta-blockers, calcium channel blockers, and nitrates** help

in improving blood pressure levels with reduction of chest pain and lowering heart's workload (Netala *et al.* 2024).

Interventional procedures

A patient suffering from CHD may need **percutaneous coronary intervention (PCI)** that involves **coronary angioplasty** and **placement of stents** or **coronary artery bypass grafting (CABG)** for restoration of blood flow (Khan, and Ludman, 2022).

Multidisciplinary care

Management needs a team effort involving General Practitioner (GP), Cardiologist, Cardiac Nurses, Dietician, Physiotherapist, Occupational Therapist, Psychologist, and the Pharmacist. These professionals are enriched to provide effective treatment and rehabilitation to patients for long-term outcomes.

Theoretical perspectives and models

UK model (Chronic care model (CCM))

As per **Chronic Care Model (CCM)**, it comprises of six elements: self-management support, multidisciplinary

approach, clinical information system, decision support based on evidence, healthcare organization, and community resources (Timpel *et al.* 2020). In UK, CCM facilitates coordination between primary care and specialized care for better adherence to treatment regimens and preventing unnecessary hospital admissions (Goh *et al.* 2022). Nevertheless, successful application of the model is contingent on sufficient staffing capacity, technology, and engagement of patients that may vary across NHS.

International model (Wagner's expanded chronic care model)

The **Wagner's Extended Chronic Care Model** is based on CCM; however, focuses on health promotion and prevention (Pomey *et al.* 2024). It acknowledges significance of healthy community settings and environment for better results in treating cardiovascular diseases, besides medical treatment. This model involves teamwork among healthcare professionals, organizations, and patients. Though it emphasizes preventive healthcare, its effective functioning needs continuous funding, collaboration among various

sectors, and strong policy support, which might not be easy in all healthcare settings.

Local and National political health and social care agendas

National strategies are essential for promoting effective prevention and management of CHD within UK. The **NHS Long Term Plan** focuses on early detection and better management of cardiovascular problems via integrated approaches (BHF, 2026). **CVDPREVENT** is an initiative that helps primary healthcare sector to detect any weaknesses in management of blood pressure, cholesterol, and diabetes (Council, and Sussex, 2026). There are evidence-based guidelines for diagnosis and treatment issued by **NICE**. The strategy **Core20PLUS5** helps in addressing cardiovascular health inequalities in vulnerable groups (Raleigh *et al.* 2022). Prevention programmes on a national level promote a healthy lifestyle and early risk detection.

Local authorities of UK and Integrated Care Boards (ICBs) collaborate with primary care networks, councils, and voluntary agencies to provide community-based programs that

can prevent CVD in their communities. However, there are inconsistencies in terms of service provision between local authorities due to shortages of personnel, lack of funding, and socio-economic differences. This has created disparities in terms of access to screening, rehabilitation, and ongoing support for CHD patients.

In local settings, **Primary Care Networks, Integrated Care Systems**, cardiac rehabilitation services, community pharmacies, and NHS Health Checks enhance coordination and prevention (Howlett *et al.* 2025). Nevertheless, there are still difficulties that need to be addressed. Inequalities at regional levels, shortage of staff, budgetary concerns, and queues hinder timely access to healthcare services. Future goals should include enhancement of preventative care, promotion of equitable access to services, implementation of community intervention strategies, and workforce development (World Health Organization, 2023). These approaches are relevant for acquiring long-term cardiovascular outcomes among UK population.

Person-centred care approach including self-management

In person-centred care, patients suffering from CHD are primary focus to decide a treatment plan. **Shared decision-making** allows patients and clinicians to come up with a treatment plan according to their needs and preferences. **Individualized care**, medication compliance, lifestyle support, and motivational interview make behavioural change possible. **Digital health technology**, NHS apps and teleconsultations, along with home blood pressure monitoring, allow early identification of any deterioration in patient's condition for improvement of treatment process (Ali *et al.* 2024).

Involvement of family will improve emotional support and help sustain healthy changes in lifestyle. Increasing **health literacy** skills among patients helps them learn more about their disease and recognize signs and symptoms of the disease and use medication appropriately (Fabbri *et al.* 2020). **Self-management skills** include regular exercise, balanced diet, stopping smoking, and attending follow-up visits. There is evidence that people who practice active participation in

self-management have less incidence of cardiovascular issues and better management of symptoms. It means that patient empowerment is still important.

Self-management and end-of-life care

Not everyone suffering from CHD needs palliative care at end-of-life stage. Nonetheless, those who are suffering from advanced stages of the disease along with severe heart failure might need palliative care services to help relieve their discomfort and improve their quality of life. **Advance care planning, DNACPR discussions**, management of symptoms, family support, and respect for desired place of care contribute to dignity of care (Islam *et al.* 2023). Ethical decision-making must consider the patient's preference through proper discussion with the doctors and the family members of the patient.

Recommendations

Improvements in prognosis for CHD need collaborative effort in healthcare and community. Early identification of high-risk patients needs to be increased through increased provision of

NHS Health Checks and risk assessment for heart disease (Thomas *et al.* 2020). **Cardiac rehabilitation programs** need to be made more available, since not all patients receive right level of cardiac rehabilitation (Taylor *et al.* 2022). Increased use of technology such as remote monitoring of blood pressure and symptoms tracking is essential for prompt treatment. Incorporation of mental health interventions is required within normal cardiac service provision to maintain issues, such as anxiety and depression.

Programs aimed at educating patients on proper management should enhance health literacy amongst patients. Continued coordination by multidisciplinary teams in offering care is required from general practitioners to specialists (Khatrri *et al.* 2023). There should be culturally-sensitive interventions to address disparities amongst different communities. Involvement of family should be encouraged within treatment and recovery processes. Efforts by communities to create healthier living should be encouraged through continuous investment; since, such programs would contribute towards lowering incidences of future cases of CHD in UK.

Where to get help and support

Access to treatment for coronary heart disease can be found at **NHS GPs**, cardiology clinics, and **cardiac rehabilitation** departments. **NHS 111** offers instant medical advice if needed. Other means of assistance include **community pharmacists**, dieticians, smoking cessation services, and mental health teams. Patients can seek advice from the **British Heart Foundation** for trustworthy information and education. Use of QR codes or NHS websites from the British Heart Foundation can aid patients for future guidance.

Conclusion

Coronary heart disease is a significant cause of illness and death and remains a priority in public health system. It identifies actions that will lead to earlier diagnosis and better risk management to prevent future ill-health and premature mortality. It makes recommendations to NHS for delivering integrated care through multi-disciplinary services, utilising best evidence-based treatment, offering comprehensive cardiac rehabilitation programmes, and support for long-term condition management. Personalised care approaches are

promoted to empower people to take control of their conditions. Long-term action will focus on prevention programmes, equal access to care, and coherent national policies to reduce health inequalities.

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