

## Introduction

Despite the efforts of epidemiologists who have brought about an understanding of risk factors inherent to ischemic heart disease, present preventive programs have not yet succeeded in reducing the morbidity and mortality rates of coronary heart disease, particularly of myocardial infarction.

Coronary care units have certainly reduced complications arising during the acute phase of an infarction. Thus, we remain confronted with many cases of coronary insufficiency or sequels of infarctions with relatively favorable clinical evolution. Many years ago, these cases had to remain at rest for a considerable time and to withdraw from active life. However, during the course of the last few years, these conditions have completely changed. The coronary patient has become acceptable for rehabilitation to a normal existence. This notion of rehabilitation (found today in numerous medical disciplines) is designed to correct the *physiological, clinical, social, and psychological* problems of the patient as well as possible. The rehabilitation must be carried out early, carefully and continuously.

Due to the efforts of numerous researchers, often coordinated by international organizations such as the Council for Rehabilitation of the International Society of Cardiology and WHO, considerable progress has been realized and formulated.

We have learned of the benefit of early mobilization and physical training beginning already during convalescence and are now in the process of justifying these new attitudes. We have learned to appreciate the importance of the psychological approach to the patient and his family. We are beginning to glimpse the importance of secondary prevention and the ability to prescribe a professional reclassification on a scientific basis.

However, much is still to be learned in these diverse fields. New research is necessary to develop a program of optimal physical training and its modalities of application. Conflicting opinions still exist as to the structure and application of these programs. Simple methods of evaluation of the physiological benefits of rehabilitation also justify more research. Psychological problems necessitate urgent complimentary investigations concerning diagnostic methods, therapies and adherence to the rehabilitation program. Relation between the residual physical capacity of the patient and his return to professional activity also calls for additional study, concerning tolerable work loads, professional stress factors, working hours and others. These studies should contribute to a better understanding of aptitude tests, work physiology and energy expenditure. Secondary preventive measures must be realized in close cooperation with epidemiologists and the benefits of long-term rehabilitation programs and their eventual cost still remain to be studied.

Finally, it is apparent that the methods and precepts of rehabilitation can be adapted to noncoronary patients also, those with valvular or congenital cardiopathies, before or after surgery, with hypertension, etc.

As expected, present programs of rehabilitation permit some of the patients an earlier return to a normal life, but further research is still needed. Research designed to define the best possible programs of action should cover all phases of coronary heart disease and other cardiopathies. Rapid progress in this field necessitates a collection of new information. Thus, we are indebted to Dr. J. J. KELLERMANN for having created this section of the Journal, *Cardiology*, thereby giving to specialists in rehabilitation, physiology, epidemiology and clinical medicine an opportunity to publish their research. It is hoped that this section will be multidisciplinary, contribute to the progress of rehabilitation and thus be of benefit to a great number of patients.