

## Is the Silent Heart Attack Really Silent?

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**Received:** September 17, 2018; **Published:** October 30, 2018

Coronary heart disease remains one of the main causes of mortality and morbidity in developed countries, both in the general population and in the elderly [1].

Acute myocardial infarction (AMI) accounts for about a third of cardiovascular mortality. It is a health problem of global relevance, affects all countries of the planet. About 17.5 million people die each year, 600,000 in the European Union and one million in the US [2]. Coronary artery disease is one of the main causes of morbidity and mortality in Cuba, according to data from the National Directorate of Medical Records and Health Statistics [1-3]. In 2017, 64.9% of deaths from heart disease occurred specifically due to ischemic diseases; of them, 45.3% due to acute myocardial infarction [4].

The Statistical Health Yearbooks describe how heart diseases, in the last five years, have been between first and second place as a cause of mortality in Cuba. The number of deceased patients has fluctuated between 22,234 (in 2012), 24,497 (in 2015) [5], cases and 27,176 (in 2017) [4], with an increase of 2263 and 2679 cases respectively. Among heart diseases, the main cause of mortality has been due to ischemic heart disease, with 15,370 deaths in 2011 and a constant increase to 16,774 in 2015 [5] and 17,628 in 2017 [4].

There are studies that suggest that because Cuba is one of the oldest countries in Latin America, it is expected that the increase in coronary disease will continue, independently of the control of other factors [6].

The incidence of coronary heart disease is more frequent in men, with a ratio of 2:1 or more to women. In other studies, they found a greater frequency of the disease from the fifth decade of life, mainly in males. It has also been reported that before the age of 45, the frequency of this entity can be up to 10 times higher in men [7].

The cardiovascular risk factors that predispose to the appearance of ischemic heart disease are known. These risk factors are obesity, advanced age (over 55 years in men and 65 years in women), diabetes mellitus, hypertension (HBP), sedentary lifestyle, chronic kidney disease, smoking, dyslipidemia, family history of premature coronary heart disease in relatives of first grade. It has also been found that obstructive sleep apnea is a cardiovascular risk factor [8].

Although the most frequent symptoms of a heart attack are chest pain, a common symptom with angina, and dyspnea or fatigue a few days before, they may not always manifest in this way. It is common, in retrospect, to remember a cut of digestion or dizziness. This is what is known as silent myocardial infarction [9].

The literature mentions that 30% of myocardial infarctions are silent, mostly in women (35% vs. 28%) [8]. This fact is of great importance, since although this type of infarction does not cause pain, its consequences are same as in the infarction with pain, with the disadvantage that the patient does not know their condition and does not maintain the treatment and care necessary to avoid complications and improve their quality of life.

The electrocardiogram (ECG) and some special blood tests that measure cardiac enzyme concentrations are diagnostic tests that help detect an acute myocardial infarction. The ECG will show the size and location of the heart muscle injury. The cardiac enzymes are inside the cells of the heart that when they die are released into the blood. Some appear a few hours later and others after a few days. Its presence confirms the diagnosis of myocardial infarction [10].

In the treatment, early therapeutic fibrinolysis reduces the size of the infarcted area, reduces mortality and improves the prognosis in the short and long term [6]. This is why the early diagnosis of AMI is so important.

The main complications of a heart attack are arrhythmias, heart failure, cardiogenic shock, pericarditis and even sudden death. But survival after a heart attack is getting higher every day, due to new advances in medicine [9]. Although it must be borne in mind that in the case of silent infarction, treatment is usually not performed in a timely manner due to the delay in diagnosis. Given this dilemma, it is necessary to question whether the silent infarction is really "silent", it is true that this type of infarction does not produce a typical pain, but in several clinical cases presented in published studies, such as the clinical case published by Plain Pazos C., *et al.* [11] it has been observed that in many cases they present banal symptoms, as in this case, a sensation of coldness in the upper limbs, therefore it is necessary, before a patient with coronary risk factors, to take into account the possibility of this disease and carry out the pertinent studies to arrive at an opportune diagnosis. At present, these examinations are of low economic cost, high availability in the health systems of most countries and fast resolution.

There are still insufficiencies in the clinical epidemiological study of silent infarction, it would be of great help, for the management of it, to have data on the behavior of this disease that help to make a diagnosis in the acute period of the same and not casuistically afterwards elapsed of the event.

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**Volume 5 Issue 11 November 2018**

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