

Prevention and Intervention as a Single Continuum of Cardiovascular Care: The Scientific Contributions to the Prevention & Intervention 2026 Central European Summit

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Cardiovascular disease is still the leading cause of death and of premature death in Europe, but the burden is not shared equally. The countries of Central and Eastern Europe have higher age-standardised cardiovascular mortality and more uncontrolled risk factors than their Western neighbours, even though the same guideline-directed therapies are available in both (Timmis et al., 2022). The distance between what is known and what reaches the patient is the reason the Prevention & Intervention 2026 Central European Summit was convened in Warsaw on 8 to 10 October 2026. From the outset the meeting was planned around a simple premise: interventional cardiology and preventive cardiology are two ends of one continuum of care, and the clinicians,

nurses, allied professionals and researchers of the region should examine the same clinical problems side by side.

This Supplement of the *International Journal of Health Supplements* collects the abstracts accepted for the Summit. Among them are cross-sectional and cohort studies, systematic and narrative reviews, and clinical case reports, submitted by investigators from Poland, North Macedonia, Serbia, Italy, the United Kingdom, Nigeria and the United States. The range of designs matches the range of questions the Summit set out to address, which runs from the management of procedural complications in the catheterisation laboratory to the social circumstances that decide whether blood

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pressure is controlled in an outpatient clinic. In what follows we outline the main themes of the collection and point to the connections between them.

A substantial group of contributions deals with complex coronary and structural intervention, and what unites them is the moment at which an apparently successful procedure takes an unexpected turn. A case from Skopje describes acute coronary occlusion caused by an intramural haematoma after drug-coated balloon angioplasty, resolved by cutting-balloon fenestration (Zarevska et al., 2026). From the same centre comes a report of refractory no-reflow during emergency intervention for acute stent thrombosis, in which intracoronary adrenaline restored TIMI grade 3 flow at the price of transient ventricular ectopy (Manev et al., 2026). A third report traces persistent angina after otherwise successful stenting of the left anterior descending artery to coronary-subclavian steal syndrome, and notes that a bilateral blood pressure measurement was the clue that directed the diagnosis (Bakracheski et al., 2026). Alongside these cases, a retrospective study examines low-dose spinal anaesthesia in patients with moderate-to-severe aortic stenosis undergoing non-cardiac surgery, and an analysis of myocardial work indices measured three months after TAVI identifies cut-off values for global constructive work and global work index that stratify long-term survival beyond ejection fraction and global longitudinal strain (Błaszkiwicz et al., 2026). The common lesson is that a technically successful procedure is a necessary but not a sufficient condition for a good outcome, and that the weeks and months after revascularisation or valve implantation deserve the same structured attention as the procedure itself, which is also the position of current guidance on acute coronary syndromes (Byrne et al., 2023).

Arterial hypertension is the most common modifiable risk factor in the region and the one in which the gap between guideline targets and everyday practice is most visible. The 2024 ESC guidelines set an intensive target of less than 130/80 mmHg for most treated adults (McEvoy et al., 2024), and three cross-sectional studies from a university hypertension clinic in Wrocław ask under what behavioural and social conditions such a target can be reached. The first finds that medication burden is the only factor shared by poorer adherence and lower illness

acceptance (Uchmanowicz, Pustelak, Kwaśny, et al., 2026). The second shows that illness acceptance remains independently associated with self-reported adherence once clinical and sociodemographic characteristics are accounted for (Uchmanowicz, Pustelak, Leszczynska, et al., 2026). The third identifies living alone as the strongest independent social predictor of uncontrolled blood pressure, with regular home monitoring working in the opposite direction (Uchmanowicz, Vellone, et al., 2026). A study from Belgrade adds a metabolic perspective, showing that the triglyceride-glucose index, the triglyceride to HDL cholesterol ratio and the cholesterol-HDL-glucose index all differ between hypertensive and normotensive young and middle-aged adults (Smiljić et al., 2026), and a narrative review from Nigeria documents a four-to-five-fold rise in hypertension prevalence among adults aged 20 to 39 years over 25 years, a trend whose relevance extends well beyond its geographical setting (Nwankwo, Okwah, et al., 2026).

Cardiovascular health in women across the reproductive life course forms a theme of its own. Adverse pregnancy outcomes are now recognised in European and American guidance as sex-specific markers of long-term cardiovascular risk that belong in risk assessment (Parikh et al., 2021), and three studies in this Supplement show how far practice lags behind that recognition. In a survey of 283 Polish parous women, hypertensive disorders of pregnancy and gestational diabetes were strongly associated with current hypertension, type 2 diabetes and dyslipidaemia, yet fewer than two in five women with an adverse pregnancy outcome had received any preventive cardiovascular check since the index pregnancy, and uptake fell steeply with time since delivery (Makara-Paciorek et al., 2026). A study from a tertiary obstetric centre in Wrocław found that only one in five postpartum women received discharge advice on home blood pressure monitoring (Drobina et al., 2026). A study of primiparous women with polycystic ovary syndrome identified older age, higher pre-pregnancy body mass index and the hyperandrogenic phenotype as predictors of gestational hypertension (Stevanovic, Smiljic, Ilic Pasquali, & Putnikovic Tosic, 2026). What these studies describe is a continuity-of-care gap between maternity services and long-term prevention, and it is a gap that nurse-led and midwife-led pathways are well placed to close.

Heart failure and its psychosocial dimension are addressed by two studies from Poznań, which relate objective markers of disease severity, right ventricular function and NT-proBNP, to patient-reported outcomes in heart failure with reduced ejection fraction. Neither TAPSE nor NT-proBNP was significantly associated with quality of life, whereas greater illness acceptance went with better self-reported health status (Pakowska et al., 2026a, 2026b). A study from Belgrade identified age, female sex, uric acid and anaemia as markers of heart failure with preserved ejection fraction in patients with non-alcoholic fatty liver disease (Stevanovic, Smiljic, & Putnikovic, 2026). Two systematic reviews turn to the psychological burden of coronary disease. One confirms the psychosocial benefit of cardiac rehabilitation in working-age adults and the importance of completing the programme (Nwankwo, Akporhwarho, et al., 2026); the other characterises heart-focused anxiety as common, prognostically relevant and rarely screened for in rehabilitation settings (Nwankwo, Ogunniyi, et al., 2026). Taken as a whole, this part of the collection supports the view that patient-reported outcomes carry information that biomarkers and imaging do not, and that a complete assessment needs both.

Lipid-related risk is the subject of two further contributions. A retrospective study from Warsaw found that combination lipid-lowering therapy was underused at discharge after acute coronary syndrome whether or not lipoprotein(a) was elevated (Szumlińska et al., 2026), and a case report from Skopje describes diffuse multivessel coronary disease in a 31-year-old patient with markedly raised LDL cholesterol, apolipoprotein B and lipoprotein(a), for whom the acute intervention was only the first step in lifelong secondary prevention (Mishikj et al., 2026). Both findings sit comfortably with the European consensus on lipoprotein(a) as a causal and under-recognised risk factor (Kronenberg et al., 2022) and with registry evidence that risk factor control after a coronary event remains inadequate across Europe (Kotseva et al., 2019).

Three observations run through the whole collection. The determinants of outcome after a cardiovascular event are increasingly behavioural, social and psychological rather than purely technical, and they can be measured with

validated instruments. Structured follow-up, whether after pregnancy, after revascularisation or after a hospitalisation for heart failure, is where the largest unrealised gains lie. And the work is unavoidably multidisciplinary: many of the studies here were led or co-authored by nurses and midwives, and several name nursing assessment and education as the point at which their findings can enter practice. This is the model that the ESC prevention guidelines describe when they place multidisciplinary teams and nurse-coordinated care at the centre of effective prevention (Visseren et al., 2021).

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