

Cardiovascular Nursing Across the Prevention Continuum: A Commentary on the Prevention & Intervention 2026 Abstract Collection

Izabella Uchmanowicz^{1,2}, Eleni Kletsiou³, Ekaterini Lambrinou⁴, Lynne Hinterbuchner⁵, Mark Hayter⁶

¹ Department of Nursing, Faculty of Nursing and Midwifery, Wroclaw Medical University, Wroclaw, Poland

² Centre for Cardiovascular Health, Edinburgh Napier University, Edinburgh, United Kingdom

³ 2nd Regional Health Authority of Piraeus and Aegean Islands, Greece

⁴ Department of Nursing, School of Health Sciences, Cyprus University of Technology, Limassol, Cyprus

⁵ Kardinal Schwarzenberg Klinikum, Schwarzach im Pongau, Austria

⁶ Faculty of Health and Education, Manchester Metropolitan University, Manchester, United Kingdom
(Corresponding Author: Izabella Uchmanowicz, izabella.uchmanowicz@eckp.wroclaw.pl)

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Nurses and midwives form the largest professional group in every European health system, and in cardiovascular care they are present at every stage of the patient's path, from risk factor screening in primary care and maternity services, through the catheterisation laboratory and the cardiac ward, to rehabilitation, long-term follow-up and care at the end of life (Visseren et al., 2021). The abstracts gathered in this Supplement, presented at the Prevention & Intervention 2026 Central European Summit in Warsaw, give an occasion to ask how this workforce contributes to the evidence base for cardiovascular prevention and what the collection says about the state of nursing research in the region. We write as cardiovascular nurses and nurse scientists connected with the Association

of Cardiovascular Nursing and Allied Professions of the European Society of Cardiology and with the editorial community of clinical nursing, and we intend this as a reflection rather than a critique.

What stands out first is how much of the collection rests on patient-reported and behavioural outcomes. Three studies from one hypertension clinic in Wrocław examine adherence, illness acceptance and social context in adults treated for hypertension (Uchmanowicz, Pustelak, Kwaśny, et al., 2026; Uchmanowicz, Pustelak, Leszczynska, et al., 2026; Uchmanowicz, Vellone, et al., 2026), and the message they share is that the obstacles to blood pressure control are rarely pharmacological. Medication burden was the only factor common to poorer adherence

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and lower illness acceptance (Uchmanowicz, Pustelak, Kwaśny, et al., 2026); illness acceptance explained adherence beyond what clinical and sociodemographic characteristics could (Uchmanowicz, Pustelak, Leszczynska, et al., 2026); and living alone cut the odds of controlled blood pressure by more than 80%, while regular home monitoring raised them (Uchmanowicz, Vellone, et al., 2026). Each of these variables can be assessed in a few minutes of a nursing consultation with a validated instrument, and each points to something nurses are trained to do: simplify the regimen together with the prescriber, teach self-monitoring in a structured way, and single out socially isolated patients for closer follow-up. The 2024 ESC hypertension guidelines acknowledge as much when they call for multidisciplinary support of treatment and for patient education on adherence and lifestyle (McEvoy et al., 2024). What the Wrocław studies add is the local, empirical detail without which such recommendations remain abstract.

The second area where the nursing and midwifery perspective is unmistakable is women's cardiovascular health. The survey of Polish parous women by Makara-Paciorek and colleagues documents a follow-up gap that midwives and cardiovascular nurses across Europe will recognise. Women with hypertensive disorders of pregnancy or gestational diabetes had markedly higher odds of hypertension, type 2 diabetes and dyslipidaemia in mid-life, yet only 38% had received any preventive cardiovascular check since the index pregnancy and only a third recalled being told that their obstetric history carried future risk (Makara-Paciorek et al., 2026). The analysis by Drobina and colleagues shows that the gap opens before the woman leaves the maternity ward, since only 20% received advice on postpartum home blood pressure monitoring (Drobina et al., 2026). International guidance leaves no doubt that adverse pregnancy outcomes should trigger structured cardiovascular follow-up (Parikh et al., 2021). The difficulty is that the transition from maternity care to long-term prevention is a handover between professions which, in most European systems, no profession owns. The midwife sees the woman when the risk is identified; the practice nurse or cardiovascular nurse sees her, if at all, years later. A nurse-led or midwife-led pathway across that interval, with explicit risk communication, a written plan for blood pressure and metabolic surveillance and a named contact, is feasible and inexpensive, and

the data in this Supplement give good reason to test it prospectively.

Heart failure and cardiac rehabilitation form the third area. The two studies from Poznań found that neither right ventricular function nor NT-proBNP was significantly related to quality of life or illness acceptance, while illness acceptance was related to better self-rated health (Pąkowska et al., 2026a, 2026b). The direction of the findings agrees with a long line of nursing research in which symptom burden, self-care behaviour and psychological adaptation explain more of the variance in quality of life than haemodynamic or biochemical measures. Nurse-led heart failure management programmes have been shown in systematic review to reduce readmission (Lambrinou et al., 2012), and the Heart Failure Association curriculum for heart failure nurses places assessment of psychosocial status and self-care at the core of the role (Jaarsma et al., 2021; Riley et al., 2016). The two systematic reviews on cardiac rehabilitation in this Supplement carry the same reasoning into coronary disease: completion of the programme emerged as a determinant of lasting psychosocial benefit in working-age adults (Nwankwo, Akporhualo, et al., 2026), and heart-focused anxiety proved common, prognostically relevant and seldom screened for (Nwankwo, Ogunniyi, et al., 2026). Keeping patients engaged in rehabilitation and recognising those whose fear of cardiac sensations is itself an obstacle to recovery are tasks that fall naturally to nurses.

The interventional and case-based contributions might seem remote from nursing practice, but we do not think they are. The reports of intramural haematoma after drug-coated balloon angioplasty, of refractory no-reflow treated with intracoronary adrenaline and of coronary-subclavian steal syndrome after successful stenting all describe a postprocedural course that departed from expectation, and in each the first signal was clinical rather than angiographic: recurrent chest pain, dizziness on arm exertion, an inter-arm blood pressure difference, ventricular ectopy on the monitor. Such signals are observed and interpreted by nurses in the catheterisation laboratory, the coronary care unit and the outpatient clinic. The case of a 31-year-old patient with NSTEMI and markedly raised lipoprotein(a) and apolipoprotein B, in whom revascularisation was described as only the first step towards lifelong secondary prevention, makes the same point

from the other side. Prevention after intervention, meaning adherence to high-intensity lipid-lowering therapy, family screening for inherited lipid disorders and sustained behaviour change, is largely nursing work, and the retrospective study from Warsaw showing underuse of combination lipid-lowering therapy at discharge after acute coronary syndrome shows how much of that work is still undone (Szumlińska et al., 2026).

A commentary written from a research standpoint should also look ahead. The studies in this Supplement have identified modifiable determinants of adherence, blood pressure control, postpartum follow-up and psychosocial recovery with validated instruments and, in several cases, with explicit adherence to the STROBE reporting guideline (von Elm et al., 2007). The natural next step for the groups represented here is to follow the cohorts they have already assembled over time, to add objective adherence measures where possible and, above all, to design nurse-led intervention studies that test whether these determinants can be changed and whether changing them improves outcomes. Cross-sectional associations identify the targets; only interventional designs will show what reaching them is worth.

The collection also tells us something about research capacity. A large share of the abstracts were written or co-written by nurses, midwives and nursing students, usually in collaboration with physicians, statisticians and international partners, and student research groups appear among the affiliations of several abstracts, which suggests that research engagement is being built into undergraduate education rather than postponed to postgraduate training. The World Health Organization has made the development of nursing research leadership a strategic priority for health systems (World Health Organization, 2021), and the Central European region has historically been under-represented in the international cardiovascular nursing literature relative to the size of its nursing workforce. Sustaining the pattern seen here will require protected research time, mentorship, access to methodological support and journals willing to publish early-stage work beside definitive studies. Conference supplements such as this one serve that purpose.

In summary, the abstracts of the Prevention & Intervention 2026 Central European Summit show that the determinants of cardiovascular outcome most open to improvement in the region are behavioural, psychological and organisational, and that these lie within the scope of nursing and midwifery practice. The collection documents shortfalls in adherence support, postpartum follow-up, psychosocial screening in rehabilitation and secondary prevention after acute coronary syndromes, and it does so with data from the clinics and wards where those shortfalls will have to be remedied. We encourage the authors to take this work into prospective and interventional designs, and we encourage the cardiovascular community of Central Europe to regard nurse-led research not as an adjunct to clinical science but as part of it.

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