Ávísun á hreyfingu - Hreyfiseðlur

Jón Steinar Jónsson
Dr. Morris surmised that the proof could be found on the stairs of those double-decker buses. In 1959, he began tracing the heart attack rates of hundreds of drivers and conductors. The drivers sat for 99 percent of their shifts; the conductors climbed about 400 stairs each working day. Dr. Morris’s data, published in 1959, indicated that the conductors had fewer than half the heart attacks of their sedentary colleagues.

In a follow-up study, Dr. Morris found that a lower incidence of heart attack among people doing physical work was not, for the most part, related to other factors, like body type. Transport for London, the city’s transportation agency, provided him with the sizes of the trouses it supplied to its workers. His data indicated that the conductors’ waistbands were smaller, but that their protection against heart attack could not be explained by their relative leanness. They had a lower risk of heart attack whether they were slim, average size or portly.

To corroborate his findings further, Dr. Morris did a study of postal workers. Comparing those who delivered the mail by walking or riding bicycles with the clerks behind the window at the post office and the telephone operators, he found that the deliverers also had a far lower risk of heart attack.

Then, in the 1960s, Dr. Morris conducted an eight-year study of the overall physical activity of 15,600 men in sedentary civil service jobs. The data showed that those who engaged in regular sensible exercise — fast walking, cycling, swimming or other sports — reduced their risk of heart attack by 50%.
Health benefits of physical activity: the evidence

Darren E.R. Warburton, Crystal Whitney Nicol, Shannon S.D. Bredin

Fig. 1: Relative risks of death from any cause among participants with various risk factors (e.g., history of hypertension, chronic obstructive pulmonary disease [COPD], diabetes, smoking, elevated body mass index [BMI ≥ 30] and high total cholesterol level [TC ≥ 5.70 mmol/L]) who achieved an exercise capacity of less than 5 METS (metabolic equivalents) or 5–8 METS, as compared with participants whose exercise capacity was more than 8 METS. Error bars represent 95% confidence intervals. Adapted, with permission, from Myers et al. (N Engl J Med 2002;346:793–801). Copyright © 2002 Massachusetts Medical Society. All rights reserved.
Hreyfing sem meðferð

- Sykursýki II
- Þunglyndi og kvíði
- Hár blóðþrýstingur
- Hjartasjúkdómar
- Offita
- Stoðkerfissjúkdómar
- Langvinn lungnateppa
- Beinþyning
- Krabbamein
FaR®
Individanpassad skriftlig ordination av fysisk aktivitet
Figur 17. Dödsfall på grund av de sex största riskfaktorerna i världen respektive Europa

Med utgångspunkt från dessa resultat bör hälso- och sjukvårdspersonal använda två nivåer av insatser till patienter som behöver öka sin fysiska aktivitet i förebyggande och behandlande syfte:

1. Till det stora flertalet erbjuds FaR, det vill säga patientcentrerade samtal och en individanpassad skriftlig ordnation av fysisk aktivitet som patienten bedriver på egen hand (vardagsaktivitet eller organiserad aktivitet).

1a. För de patienter som behöver utökat stöd för att komma i gång med fysisk aktivitet, erbjuds träningsgrupper inom vården som ett första steg.

1b. FaR kan därefter underlätta övergången från strukturerad tränging inom vården, till att individen blir varaktigt fysiskt aktiv på egen hand.
Arena fysisk aktivitet
Rekommenderad dos

Aerob fysisk aktivitet
Måttlig intensitet
Minst 150 min/vecka
Ökad puls och andning
RPE 12–13

eller
Hög intensitet
Minst 75 min/vecka
Markant ökad puls och andning
RPE 14–17

el俸
eller
kombinerat

Muskelstärkande fysisk aktivitet
Minst 2 gånger/vecka
8–10 övningar
8–12 repetitioner*

Rekommenderad dos per vecka
Fysisk aktivitet på låg intensitet

Inaktivitet

Undvik stillasittande
Under långa perioder!
Ta ”bensträckare”!

Illustration: Annika Röhl
| Person | Ístein | Fætur | Vatnsinslætt | Eftir | Nummernúmer | Byggð | Pólitafn | Ír | Fall | Hæðarhagafylki | Ystur | Skólabær | Ístjórnafélag | Hljómskeið | Óri | Áttarferðir | Íslensk | Lýsafélag | Hreinsun | Grænlendingar
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**Álandsfætur**

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Hreyfistjörnun fyrir: Jónina hans Jóns
20. mai 2013

Forskrift

Úræði

Gengiblor hvert 1,5 ór.
3 ór. treyfandi
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3 ór.
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Skýrsla til læknis

19. október 2013
Hreyfistjörnun fyrir: Jónina hans Jóns
20. mai 2013

Gráð: Gengiblor hvert 1,5 ór. í treyfandi tímanum. 1 ór. kveðstjórnun í 1 ór. tímanum. 3 ór. kveðstjórnun í 3 ór. tímanum.
Forskriftir – allt landið 2018

[Bar chart showing statistics for 2018]
Fjöldi á landinu öllu 2016 - 2018
Langtíma áhrif hreyfiseðils á virkni á SAK
Fjölnir Guðmannsson, Ósk Jórunn Árnadóttir, Jón Torfi Halldórsson

• 86 einstaklingar

• Virknisþurningar
  • 2,1 í byrjun (86)
  • 5,3 við útskrift (86)
  • 4,0 eftir 6 mánuði (86)
  • 4,5 eftir 12 mánuði (43)
  • 4,3 eftir 18 mánuði (10)
Physical activity prescription: a critical opportunity to address a modifiable risk factor for the prevention and management of chronic disease: a position statement by the Canadian Academy of Sport and Exercise Medicine

Jane S Thornton, Pierre Frémont, Karim Khan, Paul Poirier, Jonathon Fowles, Greg D Wells, Renata J Frankovich

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ABSTRACT

Non-communicable disease is a leading threat to global health. Physical inactivity is a large contributor to this problem, in fact, the WHO ranks it as the fourth leading risk factor for overall morbidity and mortality worldwide. In Canada, at least 4 out of 5 adults do not meet the Canadian Physical Activity Guidelines of 150 min of moderate-to-vigorous physical activity per week. Physicians play an important role in the dissemination of physical activity (PA) recommendations to a broad segment of the population, as over 80% of Canadians visit their doctors every year and prefer to get health information directly from them. Unfortunately, most physicians do not regularly assess or prescribe PA as part of routine care, and even when discussed, few provide specific recommendations. PA prescription has the potential to be an important therapeutic agent for all ages in primary, secondary and tertiary prevention of chronic disease. Sport and exercise medicine (SEM) physicians are particularly well suited for this role and should collaborate with their primary care colleagues for optimal patient care. The purpose of this Canadian Academy and Sport and Exercise Medicine position statement is to provide an evidence-based, best practices summary to better equip SEM and primary care physicians to prescribe PA and exercise, specifically for the prevention and management of non-communicable disease. This will be achieved by addressing common questions and perceived barriers in the field.

Prescription of physical activity (PA) is a key element of the multifaceted societal approach needed to address inactivity. Substantial evidence exists to support the benefits of exercise at least 30 chronic diseases as well as the cost-effectiveness of exercise prescription in primary care, even for cardiovascular (CV) disease alone. Physicians play an important role in the dissemination of PA recommendations to a broad segment of the population. Over 80% of Canadians visit their doctors every year and prefer to get health information directly from their family physician. Unfortunately, most physicians do not regularly assess or prescribe PA as part of routine care, and even when discussed, few provide specific recommendations.

PA prescription has the potential to be an important therapeutic agent for all ages in primary, secondary and tertiary prevention of chronic disease. Sport and exercise medicine (SEM) physicians are particularly well suited for this role and should collaborate with their primary care colleagues for optimal patient care. We must act now to correct the general lack of knowledge and training in our medical schools and residency programmes surrounding PA guidelines and prescription as well. The purpose of this Canadian Academy and
Physical activity on prescription in accordance with the Swedish model increases physical activity: a systematic review

Aron Onerup,1 Daniel Arvidsson,2 Åse Blomqvist,3 Eva-Lotte Daxberg,4 Lennart Jivegård,5 Ingrid H. Jonsdottir,6 Stefan Lundqvist,3 Anders Mellén,7 Josefine Persson,8 Petteri Sjögren,5 Therese Svanberg,9 Mats Borjesson2,9

ABSTRACT

Objectives This study investigates the effects of the core elements of the Swedish model for physical activity on prescription (PAP) by evaluating studies that compared adults who received PAP with adults who did not. All participants were adults identified by a healthcare professional as in need of increased physical activity. Primary outcome was level of physical activity.

Design Systematic review.

Eligibility criteria (1) Published 1999-2017. (2) Systematic review, randomised controlled trial (RCT), non-RCT, or case series (for adverse events). (3) ≥12 weeks’ follow-up. (4) Performed in the Nordic countries. 

Data sources Systematic searches in PubMed, Embase, the Cochrane Library, AMED, CINAHL, and Swemed+ in September 2017. Included articles were evaluated using checklists to determine risk of bias.

Results Nine relevant articles were included: seven RCTs, one cohort study and one case series. Primary outcome was reported in seven articles from six studies (five RCTs, one cohort study, 642 participants). Positive results were reported from three of the five RCTs and from the cohort study. No study reported any negative results. Swedish PAP probably increases in level of physical activity (GRADE®:⊕⊕⊕). 

Conclusions Although the number of the reviewed articles was relatively modest, this systematic review shows that PAP in accordance with the Swedish model probably increases the level of physical activity. As a model for exercise prescription, Swedish PAP may be considered as part of regular healthcare to increase physical activity in patients.

What is already known

- Physical inactivity is the fourth leading cause of non-communicable disease worldwide according to the WHO.
- A large part of the population in industrialised countries, including the population in contact with healthcare, are insufficiently physically active.
- Methods to increase the level of physical activity in patients have shown mixed results in previous systematic reviews and therefore new methods are needed.

What are the new findings

- The present systematic review shows that the Swedish physical activity on prescription (PAP) method probably increases the level of physical activity in adult patients who are insufficiently active (GRADE®:⊕⊕⊕).
- We suggest that the Swedish PAP model be used in the healthcare setting to increase the level of physical activity and be implemented as part of routine healthcare.

Although global consensus concludes that inadequate PA can cause health problems and that increased PA can improve health, evidence is still lacking with regard to optimal methods for increasing PA for people who would benefit from
Based on the higher-quality studies, it is possible to deliver a physical activity intervention for between €1120 and €15 860 per QALY gained, which is more cost-effective than many other currently-funded pharmaceutical interventions. Therefore, physical activity interventions delivered in primary health care should be considered for funding at similar levels to currently-funded pharmaceutical interventions.
Clinical practice implications of this study

The findings of our review suggest that exercise and many drug interventions are often potentially similar in terms of their mortality benefits; exercise interventions should therefore be considered as a viable alternative to, or alongside, drug therapy. Indeed, an increasing number of experts recommend prescribing an “exercise pill” as a preventive strategy to reduce morbidity and mortality.53 54 According to the US Centers for Disease Control and Prevention, roughly one third of clinicians prescribe exercise in primary care.55 However, as previous systematic reviews have shown, there is considerable uncertainty as to the effectiveness of primary care interventions for increasing physical activity.56 57 As previously recommended, primary care doctors should give brief advice to most patients about the benefits of exercise and refer patients with chronic disease to a rehabilitation programme that includes an exercise intervention.58

Comparative effectiveness of exercise and drug interventions on mortality outcomes: metaepidemiological study

Huseyn Naci researcher1 fellow, John P A Ioannidis director2

1LSI Health, London School of Economics and Political Science, London, UK; 2Drug Policy Research Group, Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston, MA, USA; 3Stanford Prevention Research Center, Stanford University School of Medicine, Stanford, CA, USA

Abstract

Objective To determine the comparative effectiveness of exercise versus drug interventions on mortality outcomes.

Design Metaepidemiological study.

Eligibility criteria Meta-analyses of randomised controlled trials with mortality outcomes comparing the effectiveness of exercise and drug interventions with each other or with control (placebo or usual care).

Data sources Medicine and Cochran’s Database of Systematic Reviews, May 2013.

Main outcome measures Mortality.

Data synthesis We combined study level death outcomes from exercise and drug trials using random effects network meta-analyses.

Results We included 16 (four exercise and 12 drug) meta-analyses. Incorporating an additional three recent exercise trials, our review collectively included 305 randomised controlled trials with 329,274 participants. Across all conditions with evidence on the effectiveness of exercise on mortality outcomes (secondary prevention of coronary heart disease, rehabilitation after stroke, treatment of heart failure, prevention of diabetes), 14,716 participants were randomised to physical activity interventions in 67 trials. No statistically detectable differences were evident between exercise and drug interventions in the secondary prevention of coronary heart disease and prediabetes. Physical activity interventions were more effective than drug treatment among patients with stroke (odds ratios, exercise v anticoagulants 0.59, 90% credible intervals 0.51 to 0.70 and exercise v antiplatelets 0.10, 0.01 to 0.62). Diuretics were more effective than exercise in heart failure (exercise v diuretics 4.11, 1.17 to 13.70). Inconsistency between direct and indirect comparisons was not significant.

Conclusions Although limited in quantity, existing randomised trial evidence on exercise interventions suggests that exercise and many drug interventions are often potentially similar in terms of their mortality benefits in the secondary prevention of coronary heart disease, rehabilitation after stroke, treatment of heart failure, and prevention of diabetes.

Introduction

Physical activity has well documented health benefits.1 Population level cohort studies have shown that people who exercise enjoy a higher quality of life and improved health status compared with those with sedentary behaviours, with subsequent reductions in their risk of adverse outcomes such as admissions to hospital. Randomised controlled trials have shown similarly favourable findings in arthritis,2 cancer,3 diabetes,4 heart disease,5 and respiratory illnesses,6 among other chronic conditions.7 Large scale observational studies have also established a clear association between exercise and all cause mortality.8 9 Given the overwhelming evidence in support of the health benefits of exercise,10 the Global Burden of Disease study has recently ranked physical inactivity as the fifth leading cause of disease burden in western Europe, and as one of the top modifiable risk factors along with smoking.11

Despite recent calls to encourage physical activity as a strategy to ward off the emerging burden of chronic conditions, including heart disease and diabetes,8 12 population level physical activity measures are disappointing. In the United Kingdom, only 14% of adults exercise regularly, with roughly one third of adults in England meeting recommended levels of physical activity.12 In contrast, utilisation rates of prescription drugs continue to rise sharply, increasing to an average of 17.7 prescriptions for every person in England in 2010, compared with 11.2 in 2000.13

Abundant evidence from randomised controlled trials shows the mortality benefits of certain drugs such as simvastatin in the secondary prevention of cardiovascular disease,14 which is
Conclusions

Supported by clear evidence of small but positive results provided by several high-quality reviews, we advocate for interventions in PC settings designed to increase PA levels of patients. Interventions that include multiple behavioral change techniques and those targeted to insufficiently active or sedentary patients seem to have better results.
Using electronic/computer interventions to promote physical activity

B H Marcus,† J T Ciccolo,‡ C N Sciammarella³

ABSTRACT
The internet has been used as a method to deliver various health interventions (e.g., weight management, smoking cessation, stress reduction, blood glucose control, reducing alcohol consumption and increasing physical activity). An electronic search (in Pubmed, Psychology, Web of Science) for internet-based physical activity interventions among adults yielded fewer than 25 studies. Although many have considered physical activity as one element of a multifactorial behavioural intervention, few have focused exclusively on changing sedentary behaviour. Overall, current results are encouraging and it appears that response to an internet-based physical activity intervention is similar to response to other established, effective interventions. Given that primary care referrals for physical activity are successful in changing sedentary behaviour to some extent, there is an urgent need for investigations into the effect of using an internet-based physical activity programme within the context of primary care. Although no studies that have combined an established internet-based physical activity programme with primary care referrals were found, there is evidence that significant progress would probably be made by providing clinicians with information on internet-based physical activity programmes.

There is now a growing body of literature on the use of the internet as a tool to promote health behaviour change. Researchers have used internet interventions for numerous topics including weight management, smoking cessation, stress reduction, blood glucose control, and reducing alcohol consumption and increasing physical activity. Currently, interventions focused specifically on changing physical activity behaviour are in their infancy, with fewer than 15 randomized controlled trials having been conducted. Thus far, the studies completed suggest that internet programmes are helpful in changing sedentary behaviour. However, more studies with larger samples and individualized treatment plans are needed, including those that take into account how primary care can facilitate a change in behaviour by utilizing internet-based health-promoting resources. In this review, we describe several internet-based studies that have produced a beneficial effect on changing participants' physical activity behaviour and present some of the limitations of these studies.

INTERNET USE
Worldwide, it is estimated that 21.9% of the population (i.e., roughly 1.5 billion) use the internet.¹ The USA and the UK are among the top 10 countries with the highest internet usage (the USA is ranked second and the UK is ranked seventh),² with 72% of 15- and 67% of UK internet users going online every day or almost every day. Although only 27% of internet users in the UK have looked for health information online,³ approximately 80% of the internet users in the USA has reported seeking health information⁴ and 44% have searched for information specifically about fitness and nutrition.⁵ In both the USA and the UK, use is high among all age groups, with approximately 90% of younger adults (aged 16-24 years) and up to 72% of older adults (aged 55 years and older)online.⁶ Rates are similar for both genders, with 78% of men and 74% of women in the USA and 71% of men and 67% of women online in the UK.⁷ Whereas there are some demographic differences among users, overall, the internet has broad reach in the USA. Although internet use is lower among those who live in a rural area (64%), those with less than a high school education (51%), or those with an annual income of less than US$30,000 (61%), use remains high among all racial/ethnic groups, with 76% of non-Hispanic whites, 65% of African Americans, and 56% of Hispanics online. Moreover, among English-speaking Hispanics, internet use exceeds that of non-Hispanic whites (79% vs. 76%).⁸

Given the above, it is clear that the internet can be used to reach a very large number of individuals, covering a wide spectrum of the population. Moreover, because individuals’ lifestyles often do not permit the time for office visits on health education and advice and physicians counsel only a minority of their patients about physical activity,⁹ the internet can also provide a more timely, convenient, and cost-effective method of information delivery, particularly when it is paired with primary care. Variants and colleagues¹⁰ estimated that providing preventive care alone, keeping with evidence-based guidelines, may take up to 8-12% for a primary care provider, highlighting the time constraints of physical activity counselling. At such, using the internet as a resource to provide physical activity advice or programming for those who would otherwise not receive it is now a potential possibility.
Eight Steps To Successful Change
- John Kotter

1. Establish a sense of urgency
2. Create a guiding coalition
3. Develop a clear shared vision
4. Communicate the vision
5. Empower people to act on the vision
6. Create short term wins
7. Consolidate & build on the gains
8. Institutionalise the change