Table I - *Characteristics of the studies*

Author Year	Objective	Kind of study	Population	Characteristics of the population	Rehabilitation cardiovascular	Comparation	Analyzed variables	Results
Seo *et al*. 2019 [16]	To evaluate the effects of 8 weeks of exercise-based cardiac rehabilitation on cardiopulmonary fitness and quality of life after RTA surgery.	Clinical Trial.	24 patients (GI =12) (GC = 12)	**GI** - Age: 58.4 ± 6.5 Weight: 73.8 ± 9.6 Paroxysmal FA: 4 Persistent FA 8 Hypertension: 3 Diabetes mellitus: 1 Dyslipidemia: 4 **CG** - Age: 59.5 ± 6.1 Weight: 72.5 ± 9.5 Paroxysmal FA: 4 Persistent FA 8 Hypertension: 6 Dyslipidemia: 2	2 sessions per week for 8 weeks with aerobic training at an intensity of 40% to 50% of RHR for 10 minutes, with progression throughout the sessions to 75% of RHR in up to 30 minutes. Resistance training was started after 2 weeks of aerobic training, performed in 2 to 3 sets with 10 to 15 repetitions. The load or intensity of resistance training was not reported.	The CG had only drug treatment.	VO_2 max and mental and physical component score of the SF-36 questionnaire).	Improvement of the physical and mental component of the SF-36 showed significant improvement.
Kato *et al.* 2019 [17]	To evaluate the effects of cardiac rehabilitation on exercise capacity, cardiac function, inflammatory status, and safety in patients with persistent AF undergoing catheter ablation.	Controlled and randomized clinical trial.	68 Patients (GI= 34) (GC = 34)	**GI** - Age: 67 ± 10 BMI: 23.8 ± 2.6 Persistent FA: 28 Long-term persistent AF (≥ 8 months): 5 Hypertension: 20 diabetes: 5 Dyslipidemia: 11 **CG** - Age: 65 ±8 BMI: 23.9 ± 3.2 Persistent FA: 31 Long-term persistent AF (≥ 8 months): 6 Hypertension: 18 diabetes: 7 Dyslipidemia: 11.	The IG performed supervised exercise 1-2 times weekly and unsupervised moderate-intensity walking exercise for 30 min, 2-3 times weekly for 6 months. Each session lasted 60min, 30min of endurance exercises at moderate intensity, 30min of resistance exercises with an intensity of 40% to 50% of 1RM.	The CG had a visit with a cardiologist at the hospital for follow-up at one, three and six months.	Physical Function; Exercise Capacity; Weight; FC; Echocardiographic parameters; inflammatory status and other blood markers;	Increase in components of physical function and exercise capacity except RER; Improved cardiac function and inflammatory status. There was no increased risk in cardiac rehabilitation.

Author Year	Objective	Kind of study	Population	Characteristics of the population	Rehabilitation cardiovascular	Comparation	Analyzed variables	Results
Rissom *et al.* 2016 [18]	To assess the effects of comprehensive cardiac rehabilitation compared with usual care on the physical capacity and mental health of patients treated with catheter ablation for AF.	RFA randomized clinical trial.	210 patients (GI= 105) (GC = 105)	**GI** - Age: 60 ± 9 BMI: 27 ± 46 Paroxysmal FA: 76 Persistent FA 29 Hypertension: 30 Diabetes mellitus: 4 Palpitation: 68 **GC** - Age: 59 ± 12.25 BMI: 28 ± 5.62 Paroxysmal FA: 76 Persistent FA 29 Hypertension: 31 diabetes: 5 Palpitation: 53.	Three sessions per week for 12 weeks. Rehabilitation was through graded cardiovascular training, intensity measured using the 15-point Borg scale, and strength exercises gradually changed during training sessions. The training intensity was progressively increased during the 12 weeks.	Usual care, including a 3- to 6-month follow-up visit with a physician	Ergospirometry (VO_{2max}), 6MWT, Sit to stand test, SF - 36, Adverse Events.	There was a significant improvement in VO_2 max. And there were no significant QOL results.

ATT = totally thoracoscopic ablation, GC = control group, GI = intervention group; AF = atrial fibrillation, HRR = heart rate reserve, 1RM = one repetition maximum, PCF = physical component scores, BMI = body mass index, 6MWT = 6-minute walk test, CM = maximal load, RER = Respiratory Exchange, LA = anaerobic threshold, HR = heart rate, ECHO = echocardiogram, QOL = quality of life; SF-36 = Abridged version of Questionnaire 36; VO_{2max} = Maximum oxygen consumption; *The studies adopted the value of P< 0.05 as statistically relevant. Source = Authors' elaboration

Table II - *Results of the studies*

	VO_2 (ml/kg/min)	6MWT (m)	Quality of life
Seo et al, 2019 [16]	Baseline: GC: 28.31± 7.44 GI: 26.91 ± 7.18 Side dish: GC: 26.85± 6.23 GI: 28.89 ± 7.63 *(P = 0.055)*		Two physical health scores (physical function, *P* = 0.013 and general health, *P* = 0.05) and three mental health scores (vitality, *P* = 0.027, social function, *P* = 0.016 and mental health, *P* = 0.003) improved significantly.
Kato et al, 2019 [17]	Baseline: GI: 17.8 ± 3.4 Side dish: GI: 19.8 ± 4.6 *(P < 0.01)*	Baseline: GC: 551 ± 84 GI: 545 ± 123 Side dish: GC: 565 ± 95 GI: 596 ±95 *(P < 0.01)*	
Rissom, et al, 2016 [18]	Baseline: GC: 20 GI: 22 Side dish: GC: 21 GI: 24 *(P = 0.003)*	Baseline: GC: 559 GI: 548 Side dish: GC: 576 GI: 592 *(P = 0.88)*	The self-reported SF-36 PCM – No significant difference between groups (53.8 points vs. 51.9 points, *P = 0.20*)

6MWT = 6-minute walk test; CG = control group; IG = intervention group; PCM = mental component scores. Source: Authors' elaboration

Table III – *Methodological quality of the studies*

STUDY	1	two	3	4	5	6	7	8	9	10	11	TOTAL	AVERAGE
Seo et al, 2019 [16]	Yea	No	No	Yea	No	No	No	Yea	Yea	Yea	Yea	5/10	
Kato et al, 2019 [17]	Yea	Yea	No	Yea	No	No	Yea	Yea	No	Yea	Yea	6/10	5.6
Rissom et al, 2016 [18]	Yea	Yea	Yea	Yea	No	No	Yea	No	Yea	Yea	No	6/10	

1 = Specification of inclusion criteria; 2 = Random allocation; 3 = Secrecy in the allocation; 4 = Initial similarity between groups; 5 = Masking of participants; 6 = Therapist masking; 7 = Masking of evaluators; 8 = Measures of a primary outcome (85% of participants); 9 = Intent-to-treat analysis; 10 = Comparison between groups on a primary outcome; 11 = Central tendency and variability of at least one variable. *Item 1 did not contribute to the total score. Source = Authors' elaboration