Updated heart disease prevention guidelines for women focus more on 'real-world' recommendations

February 15 2011

Practical medical advice that works in the "real world" may more effectively prevent cardiovascular disease in women than recommendations based only on findings in clinical research settings, according to the 2011 update to the American Heart Association's cardiovascular disease prevention guidelines for women.

First published in 1999, the guidelines until now have been primarily based on findings observed in clinical research. That alone often doesn't consider the personal and socioeconomic factors that can keep women from following medical advice and treatment.

"These recommendations underscore the fact that benefits of preventive measures seen day-to-day in doctors' offices often fall short of those reported for patients in research settings," said Lori Mosca, M.D., M.P.H., Ph.D., chair of the guidelines writing committee and a medical advisor for the American Heart Association's Go Red For Women movement. "Many women seen in provider practices are older, sicker, and experience more side effects than patients in research studies. Factors such as poverty, low literacy level, psychiatric illness, poor English skills, and vision and hearing problems can also challenge clinicians trying to improve their patients' cardiovascular health."

The 2011 update identifies barriers that hinder both patients and doctors from following guidelines, while outlining key strategies for addressing

those obstacles.

"Awareness continues to be a key driver to optimal care," said Mosca, director of preventive cardiology at New York-Presbyterian Hospital and professor of Medicine at Columbia University Medical Center. "Cause initiatives such as Go Red for Women and provider compliance programs such as Get With The Guidelines® are strong components in our efforts to broaden awareness and improve adherence among patients and providers."

She said getting a dialogue started between a woman and her doctor is a critical first step.

"If the doctor doesn't ask the woman if she's taking her medicine regularly, if she's having any side effects or if she's following recommended lifestyle behaviors, the problems may remain undetected," she said. "Improving adherence to preventive medications and lifestyle behaviors is one of the best strategies we have to lower the burden of heart disease in women."

To evaluate patient risk, the guidelines incorporate illnesses linked to higher risk of cardiovascular disease in women, including lupus and rheumatoid arthritis, and pregnancy complications such as preeclampsia, gestational diabetes or pregnancy-induced hypertension. Mosca said women with a history of preeclampsia face double the risk of stroke, heart disease and dangerous clotting in veins during the five to 15 years after pregnancy. Essentially, having pregnancy complications can now be considered equivalent to having failed a stress test.

"These have not traditionally been top of mind as risk factors for heart disease," she said. "But if your doctor doesn't bring it up, you should ask if you're at risk for heart disease because of pregnancy complications or other medical conditions you've experienced."

The updated guidelines also emphasize the importance of recognizing racial and ethnic diversity and its impact on cardiovascular disease. For example, hypertension is a particular problem among African-American women and diabetes among Hispanic women.

Although putting clinical research into practical, everyday adherence can be challenging, solid scientific evidence is still the basis for many of the guidelines, Mosca said. Some commonly considered therapies for women are specifically noted in the guidelines as lacking strong clinical evidence in their effectiveness for preventing cardiovascular disease and, in fact, may be harmful to some women. Those include the use of hormone replacement therapy, antioxidants and folic acid.

The update includes depression screening as part of an overall evaluation of women for cardiovascular risk, because while treating depression has not been shown to directly improve cardiovascular health, depression might affect whether women follow their doctor's advice.

Despite a growing body of clinical evidence to fight heart disease and stroke in women, more is needed, Mosca said. Coronary heart disease death rates in women dropped by two-thirds from 1980 to 2007, due to both effective treatment and risk factor reduction, according to the American Heart Association, but cardiovascular disease still kills about one woman every minute in the United States.

In future studies, researchers should look at interventions during specific times throughout a woman's lifespan — including puberty, pregnancy and menopause — to identify risks and determine effective prevention opportunities during those critical times, Mosca said. More cost-effective analyses and clinical trial research with male- and female-specific results are also needed, especially regarding risks posed by preventive therapies.

"Now that science has shown the benefits are often similar for men and women, there is a need to understand if the risks are also similar and acceptable," she said.

"These guidelines are a critical weapon in the war against heart disease, the leading killer of women," Mosca said. "They are an important evolution in our understanding of women and heart disease. And I cannot stress personal awareness and education enough. Initiatives such as Go Red For Women give women access to the latest information and real-life solutions to lower their risk of heart disease."

Provided by American Heart Association