Women have heart attacks too, but their symptoms are often dismissed as something else

August 8 2017, by Patricia Davidson

Heart attacks claim the lives of 3.3 million women every year, and many women die from other heart-related conditions. In the United States, nearly 290,000 women died from heart disease in 2013 – that's about one in every four female deaths.

In Australia, a recent report found over 31,000 women died from heart disease every year, far more than the 12,000 women who died from common forms of cancer, including breast cancer.

And while more men than women are admitted to Australian hospitals every year for heart disease, the numbers who die are equal between the sexes. This is because heart disease is less recognised in women than in men, due to its uncommon symptoms and the fact women are less likely to seek help quickly.

A recent Australian study also found women from lower socioeconomic backgrounds are 25% more likely to suffer a heart attack than their male counterparts.

For many years, the importance of women's heart health has been invisible. It has only come to be recognised in the last decade. In 1997, only 30% of American women surveyed were aware cardiovascular disease (which includes heart disease and stroke) was the leading cause of death in women. Despite multiple media campaigns, this had risen to

just over 50% of women in 2009.

Different symptoms

Both sex and gender need to be considered when discussing heart disease in women. While these terms are often used interchangeably, there are important differences. Sex refers to physiological characteristics, while gender refers to socially defined roles, behaviours and expectations.

We are only now starting to understand sex-and-gender-based differences in women with cardiovascular disease, as for many years women were not included in clinical trials. Risk factors for heart disease, as well as the way it manifests itself, can be different between men and women.

Risk factors common to both sexes include high cholesterol, smoking, obesity and physical inactivity. But gestational diabetes, preterm delivery, hypertension in pregnancy and breast-cancer treatments are specific to women.

Having an autoimmune disorder also increases the risk of heart disease. And because more women than men have autoimmune disorders, this is more relevant for women.

Likewise, mental illnesses such as depression and post-traumatic stress disorder (PTSD) are more common among women. And researchers are increasingly becoming interested in the associations between such psychological factors and heart disease, particularly in women.

The faster a heart attack is treated after it occurs, the less heart muscle is lost and the lower the risk of death and disability as a result. For both men and women the most common symptom of a heart attack is chest pain. But women can experience less typical symptoms such as shortness

of breath, weakness, fatigue and nausea. Women can also feel the chest-related symptoms in different locations to men such as in the neck, jaw and back.

These less typical symptoms in women sometimes mean heart attacks are misdiagnosed. The reasons for these different symptoms is that heart disease in women has less obstructive patterns in the coronary arteries (vessels that supply blood to the heart).

Women are older at diagnosis

Heart failure occurs when the heart does not provide enough blood for the body's needs and commonly manifests in symptoms such as fatigue and breathlessness. Heart failure in women typically occurs at an older age.

Women are also more than twice as likely as men to develop a type of heart failure known as heart failure with preserved ejection fraction (HFpEF). This condition is associated with high rates of early death, and impaired quality of life. High blood pressure (hypertension) is a strong risk factor: 80-90% of patients with HFpEF have high blood pressure.

To date there remains no definitive treatment for HFpEF, although clinical trials are ongoing.

Women are generally ten years older than men when they experience their first cardiac event. This increases the likelihood they have other conditions, such as arthritis and diabetes, which leads to worse outcomes.

Older women also commonly live alone, as they are more often widowed than men. They are likely to have reduced financial resources as well as a need for increased instrumental support in daily activities. This can

mean they are less able to make their appointments or get their prescriptions filled.

The situations older women often find themselves in when diagnosed with a cardiovascular condition reduce their chances of getting adequate exercise. Exercise is important to optimise heart function and promote physical function for healthy ageing. Older women need to be provided with structured mechanisms to help them be physically active.

Outpatient programs known as cardiac rehabilitation, which involve several disciplines including nurses, doctors, dietitians, exercise physiologists and occupational therapists, reduce early death and are endorsed in clinical practice guidelines across the world. These programs address risk factors and teach people how to manage their illness.

Although previously recommended mainly for individuals suffering a heart attack or coronary artery bypass surgery, the programs are increasingly recommended for those suffering heart failure. Unfortunately, a synthesis of available information shows that, in the US, men were a third more likely to be enrolled in these compared with women.

This could be for many reasons. Some health professionals and referral patterns influence participation in such programs. But we also know even when women are referred they often do not attend. The reasons include lack of transportation, a lower ability to exercise and the pressure of care-giving responsibilities.

This is another example where gender-focused strategies need to be developed to lessen the toll of heart disease on women.

Helping women take control

Improving outcomes from heart disease in women will need a change not only in health professionals' knowledge, attitudes and beliefs, but most importantly among women themselves.

The first step for women to lower their risk is to get them to prioritise their own health, by increasing their knowledge of risk factors and symptoms particular to women. There are also some important lifestyle factors to consider. These include:

consulting with your health professional about cardiovascular screening based on your family history and risk factorsavoiding smoking and seeking assistance if you are a smokerhaving an exercise plan and addressing stress and depressionenjoying a healthy diet that is low in saturated fat and high in fibre, and avoiding processed foods.

The future

We have progressed in our recognition of both sex and gender differences in heart disease, but many questions remain unanswered, particularly in women from underrepresented minority groups. Mandated quotas to include women in trials have helped, but women are still under-represented in clinical trials and we lack of research into the specific needs of women.

Women do live longer, but this often comes with disability which has adverse impacts on individuals and society. It is exciting to see emerging clinical practice guidelines for both primary prevention of cardiovascular disease and acute myocardial infarction focusing specifically on women.

As well as monitoring biological factors, such as blood pressure, weight, blood sugar and cholesterol, women also need to address psychological and social factors, such as stress and depression. We need to develop health care programs using a gender-based approach to increase

awareness of heart disease as a women's health issue and improve health outcomes.

This article was originally published on The Conversation. Read the original article.

Provided by The Conversation