

Women with heart disease less likely to reach treatment targets than men

September 20 2017

Women with coronary heart disease are less likely to achieve treatment targets than men, finds a study published by the journal *Heart* today.

The authors say a better understanding of sex disparities is needed to treat women with [coronary heart disease](#) more efficiently in all regions, especially in Asia and the Middle East.

Coronary heart disease (CHD) remains one of the leading causes of death and disability worldwide. Despite convincing evidence on the benefits of managing [risk factors](#) in people with established CHD (such as lowering [blood pressure](#) and cholesterol levels and being physically active) an unacceptably large proportion of affected individuals do not reach recommended risk factor targets.

So a team of international researchers set out to investigate whether there are [sex differences](#) in risk factor management of patients with established CHD, and explore some of the reasons behind this.

They analysed data from just over 10,000 patients (29% women) with CHD from Europe, Asia, and the Middle East between 2012-2013. On average, women were 4 years older than men. Adherence to guideline-recommended treatment and lifestyle targets was recorded as a Cardiovascular Health Index Score (CHIS).

Overall, only 6% of women and 8% of men reached all treatment targets and about one-third of men and women met all lifestyle targets.

After adjusting for several factors that could have influenced the results, they found that, compared with men, women were less likely to achieve targets for total cholesterol (8% vs 14%), LDL cholesterol (22% vs 33%) and blood glucose (71% vs 76%), or to be physically active or non-obese. In contrast, women had better control of blood pressure (45% vs 38%) and were more likely to be a non-smoker than men.

Overall, women were less likely than men to achieve all treatment targets or obtain an adequate CHIS, but no significant differences were found for all lifestyle targets.

Sex disparities in reaching treatment targets were smaller in Europe than in Asia and the Middle East. Women in Asia were more likely than men to reach all lifestyle targets, but the reverse was seen in Europe and the Middle East.

The findings were similar after further adjusting for risk factors.

The authors outline some possible reasons for these differences. For example, women are more likely to be underdiagnosed and are less likely to take medication, such as statins, than men.

They conclude that risk factor management for the secondary prevention of CHD was generally worse in women than in men, and the magnitude and direction of the sex differences varied by region, "suggesting the need for tailored strategies to reduce these inequalities and to improve the uptake of guideline-recommended care for the secondary prevention of CHD in both men and [women](#)."

A linked editorial by US researchers says this study adds important international data regarding sex differences in ischaemic heart disease (IHD) risk factor management.

Knowledge gaps remain, they write, and they call for further investigation into the reasons behind large sex differences in risk factor management. The need for country and region-specific IHD data stratified by sex is also needed to optimise personalised medicine, they conclude.

More information: Sex differences in risk factor management of coronary heart disease across three regions,
heart.bmj.com/lookup/doi/10.1136/heartjnl-2017-311429

Editorial: Sex differences in coronary heart disease risk factors: rename it ischaemic heart disease! heart.bmj.com/lookup/doi/10.1136/heartjnl-2017-311921

Provided by British Medical Journal

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