Researchers: Separate stroke and heart attack risk predictors necessary

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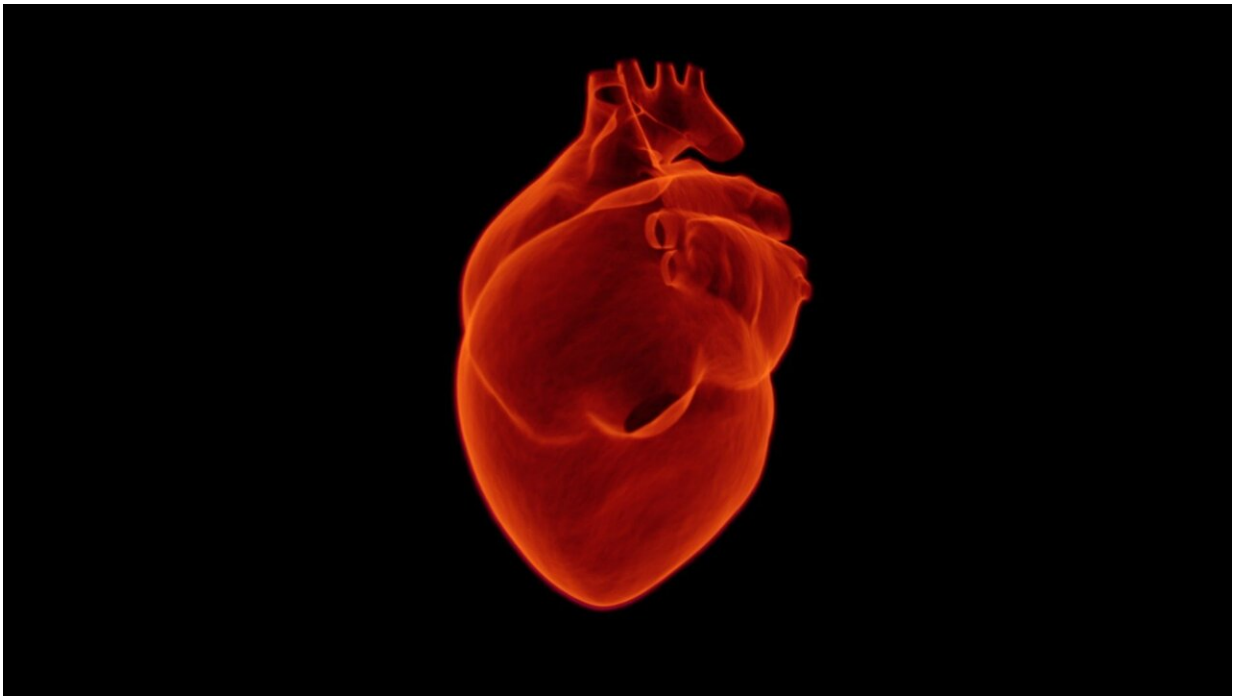

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A study involving Te Herenga Waka—Victoria University of Wellington's Dr. Denise Taylor and led by Associate Professor Susan Wells from the University of Auckland calls for separate stroke and heart attack risk predictors to improve understanding of those at risk.

Separate risk equations are needed to help older people better understand

how to lower their risk of strokes and heart attacks, finds the University of Auckland Health Research Council-funded study, published on 1 October in the *British Journal of General Practice*.

Dr. Taylor, a senior lecturer in the School of Nursing, Midwifery, and Health Practice in the Faculty of Health—Te Wāhanga Tātai Hauora, says the research indicates separate, more individualized risk scores for cardiovascular disease (CVD) are needed, alongside individualized advice from clinicians.

The study looked at older people's understanding of their risk for CVD.

CVD is a leading cause of death and health loss in older people, and the risk increases with age. Current cardiovascular disease risk equations predict the likelihood of a combined set of outcomes such as fatal and non-fatal heart attack, stroke, as well as other conditions such as angina, over the next five years.

Study participants were generally unaware CVD could be predicted and therefore prevented.

All but two of the 39 participants in the study wanted to know their CVD risk, and more specifically, their risk of stroke and of heart attack as separate events. The remaining two participants believed their fate was in God's hands, Dr. Taylor says.

"Many participants did not realize the cardiovascular disease risk score also included risk of stroke, a disease they found more worrying than a heart attack."

"Many thought a heart attack was treatable with stents or a bypass—it happens and then it's fixed, or at least it causes less dependency or a swifter death. A stroke was perceived differently—many had seen the

impacts of this on other family members. They were aware this could reduce their mobility and independence, and felt they could become a burden to their family."

"Many did not know these conditions could be prevented with medication," she says.

While it might be easier for clinicians to use one combined CVD risk score, "it did not help people make decisions about how to reduce their individual risk."

"We suggest a more individualized approach may help people understand their own risks more clearly and empower them to make lifestyle changes to reduce their risk, as well as regularly taking preventative medication," says Dr. Taylor.

The study involved 39 participants of Māori, Pacific, South Asian, and European ethnicities between the ages of 61 and 91. All but two of the 39 participants were on CVD-related medication but were not well informed—including some who did not know they had CVD or the signs and symptoms of a heart attack or stroke.

"What was also clear is that people received non-specific guidance from their doctor," she says. "For example, that they needed to lose weight or eat better for example, but not how much weight to lose or what to stop eating or change."

"We also have a mismatch between the language and tools GPs use around CVD risk—they might describe it as blood pressure or hypertension for example, without really telling people what that means or what the longer-term risks are."

This can be particularly challenging where language barriers already

exist. For example, in the Elder Tongan language there is no word for cardiovascular disease, Dr. Taylor says.

More information: Denise Ann Taylor et al, Cardiovascular disease risk prediction in older people: a qualitative study, *British Journal of General Practice* (2021). DOI: 10.3399/BJGP.2020.1038

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