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Assessing Advancements in Cardiology: Women & Heart Disease

Dr. Sorrentino:
It may be hard to believe, but only half a century ago, heart disease was thought of as typically a man's disease. And while we've certainly made advancements in our understanding and management of this deadly condition, there's still more work to be done to protect those that are at great risk of this health threat, specifically, a patient group that makes up the other half of the entire U.S. population: women.

Welcome to Heart Matters on ReachMD. I'm Dr. Matthew Sorrentino and joining me to discuss women and heart disease is Dr. Nanette Wenger, a Professor of Medicine in the division of cardiology at Emory University School of Medicine. Dr. Wenger, it's a real honor to have you on the program today.

Dr. Wenger:
I am delighted to be here talking with you.

Dr. Sorrentino:
To start us off, do women have the same risk of heart disease as men?

Dr. Wenger:
Actually, Matt, what we see is that women and certainly subgroups of women may be at equal or even greater risk. As you mentioned, previously heart disease was thought of as a man's problem and probably the reason was that the men developed their heart disease younger and the initial manifestation of coronary disease in men was often a heart attack, whereas women had angina. And going back to the Framingham data, we realized that women, indeed, had more angina than did men, but perhaps, the epidemiologists didn't have concern about it because it wasn't immediately fatal. Remember that in those years, myocardial infarction, which was the "man's problem" entailed a 40 to 50% risk during the acute hospitalization, so what we have come to realize is that the spectrum of coronary disease, at the time of the Framingham heart study, and what we see today, is very different. And the major advances for women have been the identification of sexes of biological variables, so that with coronary disease, women have different issues regarding prevention, recognition, and management.

Dr. Sorrentino:
I've had some women come to me in the office and say that women get different symptoms than men; they don't get chest pain. Is that true, or are we not understanding the symptoms that women typically present with?

Dr. Wenger:
Well, I expect we're talking about two different spectra. One is angina and the other one is myocardial infarction. And certainly, women still have chest pain as the dominant presentation of both, but women tend to present with a multitude of symptoms. They may have shortness of breath, fatigue, arm, neck, back, shoulder, abdominal pain, anxiety, and sometimes the chest pain gets lost in the refutation. But one of the features in the recognition of acute myocardial infarction that I have worked with my emergency room doctors to ascertain is that any acute symptom between the jawbone and the umbilicus must be considered acute myocardial ischemia and evaluated. Now with angina, some women may have only breathlessness or only exercise or exertion-related fatigue, but if you query you often will have a chest discomfort story. It is often not described by women and men as pain, because it's more of a pressure, a heaviness, an oppression, so sometimes listening to the patient rather than trying to get a yes or a no answer is a much better way of getting a very good clinical history.

Dr. Sorrentino:

Does the prevalence of heart disease among women differ in certain ethnic and minority groups?

Dr. Wenger:
If we discussed just coronary heart disease, rather than many of the other heart diseases, we certainly see more disease among racial and ethnic minorities and, as in men, the south Asian population is particularly vulnerable to coronary heart disease.

Dr. Sorrentino:
So, despite this prevalence of heart disease in women, it often goes unnoticed, or at least gets diagnosed late. Can you tell us why this may be the case in women?

Dr. Wenger:
I expect there are two features. One is the patient and the other is the healthcare provider. And remember that if women are not aware that a female heart is vulnerable to heart disease, they will not listen to messages about prevention, detection, and control risk factors and will often not even heed the symptoms, calling them indigestion or something of that sort. And the same is the case for healthcare providers because there is no question that even though we have changed the education curriculum of all of our healthcare providers to examine sex-related issues, there is still a perception among many healthcare providers that women are less vulnerable. There was a fascinating online study done, oh, perhaps a decade ago where the identical clinical history was offered but the face was either a woman or a man and uniformly, a whole variety of healthcare providers assigned a greater risk status to the man and were more apt to do diagnostic testing and/or therapy.

Dr. Sorrentino:
So, you mentioned the prevalence of heart disease in women can be very high, but what about the diagnostic testing that we do; is it as accurate in women?

Dr. Wenger:
Well, again, we have to examine what is the landscape of coronary disease between the sexes. And for men, typically, the coronary disease relates to obstructive disease of the epicardial coronary arteries, but women are more complex. Certainly, there is obstructive disease of the epicardial coronary arteries, but women also have a higher prevalence of non-obstructive coronary disease and of microvascular disease and that remains equally serious. This paradigm was illucidated by the NIH WISE study, and in order to be enrolled in WISE, women had to have myocardial ischemia documented at any of a variety of non-invasive tests; they all were hospitalized and had coronary arteriography and lo and behold, as was seen in clinical practice, about half of them did not have significant obstructive disease of the epicardial coronary arteries. In clinical practice, at that time, people would have shrugged their shoulders and said, “false positive, non-invasive test”, well, as I’ve said, this is a phrase that has to be removed from our vocabulary because it was not a false positive, non-invasive test, it indicated myocardial ischemia and myocardial ischemia kills. And because they were in a study, they were followed and because they had myocardial ischemia, they had hard events: myocardial infarction and coronary death. So, certainly, any test that shows myocardial ischemia is important. We are now beginning to do a great deal better at detecting microvascular disease in a far less invasive way, but we are almost there, but we’re not quite there, yet.

Dr. Sorrentino:
For those just tuning in, you’re listening to Heart Matters on ReachMD. I’m Dr. Matthew Sorrentino, and I’m speaking with Dr. Nanette Wenger about women and heart disease. So, Dr. Wenger, we’ve discussed the prevalence of heart disease among women, how can we better address the disparity in diagnosis for our women patients? What changes can we implement in our day-to-day practice to really understand the threat that’s facing our women patients?

Dr. Wenger:
Well, I really would like to go even a step farther back than diagnosis and that is prevention. And certainly, if women are aware that the female heart is vulnerable to heart disease, they will address the risk factors that predispose them to heart disease. So, essentially, what we have to do as a healthcare community first is to reinstitute a very active and aggressive educational campaign to see that the preventive modes are taken into account and then reeducate our healthcare community to examine the women who seem to be early on at risk. And certainly, the conventional risk factors are really very, very important, but in the primary prevention guideline that the American Heart Association American College of Cardiology put out last year, there are a number of features called “risk enhancers” that put women and men at increased risk that are not measured in the conventional risk factors, and specifically for women, those would be: early menopause, but I want to highlight systemic autoimmune disease and complications of pregnancy. The woman who has hypertension during pregnancy, preeclampsia, small for gestational age baby, preterm delivery, all of these are markers of a subsequent increase in risk. And these women should be identified early on in cooperation between the internist, cardiologist, and the OB/GYN and examined for risk factors that may appear fairly soon after the pregnancy. You know, there was another study looking at the status of heart health of comparably-aged pregnant and non-pregnant women. And for a grade out of 1 to 10, 1 being the best heart health, what

we saw is that fewer than 1 in 10 pregnant women had really good heart health and the general heart health, as measured by conventional risk factors, was less among pregnant women than it was among non-pregnant women. Now, these are women who are under care, so I expect this is an opportunity, really, to intervene.

Dr. Sorrentino:
You certainly mentioned the increased awareness we need to bring to our healthcare deliverers, but what can we do on a global scale, on a national scale to increase awareness of heart disease, especially in our younger women?

Dr. Wenger:
Well, remember decades ago, when hypertension was identified as a major problem, we had a national public health campaign. We are currently realizing the weakness of our public health infrastructure in the response to COVID and I expect that public health infrastructure will be remedied over time. But that is the infrastructure that has to be used to teach heart health beginning in the grade schools and certainly have heart health as part of the educational curriculum in schools. That's for the young people, but also young people bring the messages home to their families. And then in the communities we have to partner with community organizations, where is it that our potential patients are? A wonderful study was done just a few years ago in the barbershops, just showing that messages about hypertension in the barbershops reached an audience. Obviously for the women, we will do it in the nail shops and in the hair salons, but we have to go where patients are.

Dr. Sorrentino:
And finally, if you can give one call of action to your colleagues regarding the risk of heart disease in women, what would that be?

Dr. Wenger:
I would tell them that the female heart is vulnerable; listen to your patient, let the patient tell you the symptoms so that you make the decision as to which diagnostic tests are appropriate and when they have to be instituted. And the answer is "probably sooner rather than later." But I do want to return to the preventive mode and to realize that because women are vulnerable, they deserve the same approach to prevention as do their male peers. But particularly, to emphasize that a history of pregnancy complications is critical to assess cardiovascular risk in women and often this, in young women, is where you will discover the women who are at risk and who may benefit from addressing initially the American Heart Association's Life's Simple 7.

Dr. Sorrentino:
With that call to action in mind, I want to thank my guest, Dr. Nanette Wenger, for joining me to discuss her experiences and insights into women and heart disease. Dr. Wenger, it was an honor to have you on our program today.

Dr. Wenger:
My pleasure.

Dr. Sorrentino:
I'm Dr. Matthew Sorrentino. To access this and other episodes in our series, visit ReachMD.com/programs/HeartMatters, where you can Be Part of the Knowledge. And thanks for listening.