



test) have the typical coronary stenosis (blockage) severity that is significant defined as more than 50% which is most likely the reason that they are treated less aggressively.⁴

After the Women's Health Study was published in another leading medical journal, NEJM in 2005, there has been some controversy in regards to aspirin and primary prevention of heart disease in women. The current recommendations are; that women under the age of 65 not receive primary prevention with aspirin, unless they have significant risk factors.

In conclusion, women and clinicians need to become more aware of the morbidity and mortality of women and cardiovascular disease. In theory this, should improve diagnosis and treatment as well as hospitalization rates, recurrent ischemia, and mortality.



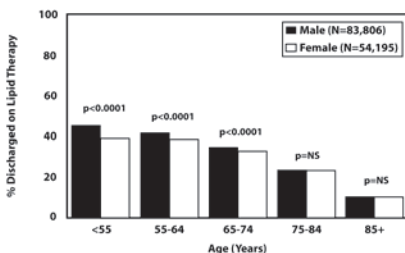
**Story by
Dr. Mona Shah**

References:
 (1) Canto, John, et al. JAMA 2000; 283:3223-3229
 (2) Pope, et al. NEJM 2000; 342: 1163-1170.
 (3) Fonarow, et al. Circulation 2001; 103:38-44.
 (4) NIH/NJBLI. JACC 2006.

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with an acute myocardial infarction, reported no chest pain. They were predominately older, predominately female, and had a higher prevalence of diabetes. Women were less likely to be diagnosed with an acute infarction and higher in hospital mortality (death) rates.

Women will also more likely present atypical symptoms and equivocal (non-specific changes) EKG changes. During coronary angiography (cardiac catheterization) women demonstrated less significant evidence of coronary stenosis (blockage) and were treated less aggressively.² In fact, compared to men women were given less lipid lowering treatment in every age below 75.³

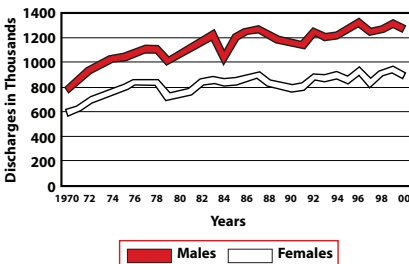


Compared to men, women with acute coronary syndromes (unstable chest pain of cardiac origin) have less interventions, coronary artery bypass surgeries and aggressive medical management due to the definitions of coronary stenosis. Although their rate of cardiovascular deaths were not affected their rate of refractory ischemia and hospitalizations were significantly increased compared to men. They are often less likely to receive an EKG within ten minutes of arriving to the emergency department, less likely to be cared for by a cardiologist and less likely to receive certain specific important cardiac medications i.e. glycoprotein IIb/IIIa inhibitors, heparin, or ACE inhibitors.

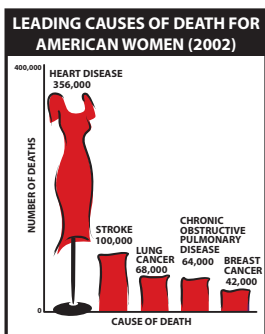
Only 1/3 of the women with ischemia (decreased blood flow on nuclear stress

Women & Cardiovascular Disease

It is fairly well known that the most common cause of death for men is coronary artery disease. However, for women it is still thought by the majority of the population that breast cancer is the leading cause of morbidity and mortality (death) in



women. In fact, the mortality rates of cardiovascular disease for women are on the rise compared to men where it is on the decline. Awareness is improving. In 1997, 50% of women presumed that breast cancer was the leading cause of death which declined to 35% in 2003. This is a significant improvement in our education of women and health care providers in regards to women and cardiovascular disease. 1 in 30 women will die from breast cancer compared to 1 in 2.6 that will die from cardiovascular disease (heart or vascular disease).



In regards to acute myocardial infarction (heart attacks), women under the age of 50 are twice as likely to die from the event as men. JAMA¹, a leading medical journal, reported in 2000 that 33% of patients

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