Roger S. Blumenthal, M.D., is a recognized authority on preventive cardiology and heart disease in women. A national spokesperson for the American Heart Association, Dr. Blumenthal serves on the Cardiovascular Disease Prevention committee of the American College of Cardiology. He is an Associate Professor of Medicine, Division of Cardiology at the Johns Hopkins University School of Medicine and Director of the Johns Hopkins Ciccarone Center for the Prevention of Heart Disease and Hopkins Heart Health in Timonium.

The Advanced Studies in Medicine (ASiM) senior contributing editor for this issue interviewed Dr. Blumenthal about cardiovascular disease prevention in women and the American Heart Association guidelines.

ASiM: Based on the latest findings on hormone replacement therapy (HRT) and reduction of cardiovascular events reported in the Women's Health Initiative (WHI) and Heart and Estrogen/Progestin Replacement Study follow-up (HERS II) studies, what are your recommendations for postmenopausal women at risk for cardiovascular events?

Dr. Blumenthal: These studies clearly indicate that HRT should not be used specifically to reduce the risk of cardiovascular events. Currently, the Raloxifene Use for the Heart (RUTH) trial is investigating whether raloxifene, a selective estrogen receptor modulator used for the prevention and treatment of osteoporosis, can lower the risk for cardiovascular events in postmenopausal women.

ASiM: How prevalent is coronary heart disease (CHD) in American women?

Dr. Blumenthal: CHD is the leading cause of death among American women as well as a significant cause of morbidity. Statistics indicate that first cardiovascular events are more likely to be fatal in women, and CHD is more common in women as they age. Because many postmenopausal women have some combination of risk factors, their physicians need to discuss CHD risk with them and be prepared to evaluate and manage these risk factors.

ASiM: What are the risk factors for CHD in women?

Dr. Blumenthal: Modifiable risk factors include smoking, obesity, type 2 diabetes, elevated blood pressure, and elevated serum cholesterol level; minimizing the risk factors is important for CHD prevention. Age and family history are risk factors that cannot be altered.

ASiM: What can postmenopausal women do to minimize the risk factors?

Dr. Blumenthal: Smoking cessation is important, as well as avoiding passive cigarette smoke. In many cases, blood pressure can be decreased by conservative measures, such as weight loss, increased physical activity, moderate sodium intake, and moderate alcohol intake, if consumed. Type 2 diabetes is often associated with a sedentary lifestyle and being overweight; in many cases, dietary changes, physical activity, and weight loss can conservatively manage this condition. Recommendations for risk factor management and the aggressiveness of the program will depend on the individual patient's future probability of a cardiovascular event.

ASiM: What should patients with elevated serum cholesterol levels do?

Dr. Blumenthal: Patients with elevated serum cholesterol levels may improve lipid profiles by following the lifestyle changes previously discussed. Patients with high levels of low-density lipoprotein cholesterol (LDL-C) may be prescribed lipid-lowering therapy. Current guidelines define high LDL-C levels based on
the patient’s risk factors or risk equivalents: 160 mg/dL or higher in patients with 0 to 1 risk factors, 130 mg/dL or higher in those with 2 or more risk factors, and 100 mg/dL or higher in those with CHD and CHD risk equivalents. High-risk patients should be considered for more aggressive treatment. This patient group includes postmenopausal women with high LDL-C levels or other risk factors. A therapeutic regimen with 1 or more lipid-lowering medications may be indicated for women with abnormal lipid profiles.

ASiM: When is the optimal point in a woman’s life to discuss cardiac risk factor management?

Dr Blumenthal: Risk factor management should begin in early adult life (by age 20). An ideal time to approach this discussion with women is during the preconception period or during pregnancy. At every routine evaluation, physicians should assess smoking status, alcohol use, physical activity, blood pressure, pulse, body mass index, and waist circumference. This can be an optimal time to discuss health behaviors that reduce future risk. Regardless of counseling earlier in life, risk factor screening and counseling should be done in postmenopausal women. Current American Heart Association (AHA) guidelines have gender-specific data for some areas, and although this data can serve as a guide to risk factor management, it cannot replace clinical judgment.

ASiM: Do clinicians have sufficient opportunity during routine visits to counsel patients about prevention of cardiovascular disease?

Dr Blumenthal: Counseling patients during routine office visits is an area of missed opportunity for many physicians. Although the AHA and the US Preventive Services Task Force recommend that primary care providers offer counseling as part of the preventive health examination to promote physical activity, a healthy diet, and smoking cessation, physicians are not discussing prevention of CHD, or the more encompassing cardiovascular disease (CVD), during routine visits. Data obtained from the Centers for Disease Control (CDC) National Ambulatory Medical Care Survey in 1995 indicated that a high proportion of office visits for routine gynecologic care or general medical care did not include counseling for the prevention of CVD. Unfortunately, even though women were more than twice as likely as men to seek routine care, men received counseling more often than women in the areas of physical activity, diet, and weight reduction. CVD is not a specific event—it is a continuum of a progressive disease process. Current AHA guidelines recommend the development of a physician-patient partnership in which the physician assesses and communicates risk to the patient as well as codevelops a preventive action plan with the patient.

ASiM: Why do you think so few physicians counsel patients in primary prevention during routine office visits?

Dr Blumenthal: Some physicians may not feel they have the appropriate information, and some may feel that providing this information is not their responsibility. In one survey, nearly three fourths of the physicians felt they were not adequately prepared to provide dietary counseling. Many physicians reported that time constraints, lack of reimbursement, and lack of professional training are barriers to counseling patients. The time needed to counsel patients is usually more than is allotted during a routine examination. Patients may need detailed information, such as diet analysis or exercise programs, that simply take too much time and too many resources. As suggested in the AHA guidelines, practice-based systems need to be developed for risk factor management in patients at cardiovascular risk.

REFERENCES