

Top Ten Things To Know

Preventing and Experiencing Ischemic Heart Disease as a Woman: State of the Science

1. The purpose of this scientific statement was to compile the most current research related to IHD in women and to focus on studies that document a woman's experience and those influential factors that can affect women receiving a correct diagnosis and then timely treatment for IHD. This paper includes coronary artery disease.
2. Women have poorer outcomes than men after initial IHD presentation. Women have more complications after a first AMI such as increased bleeding risk after percutaneous coronary intervention and a greater portion of women than men with angina and ACS have nonobstructive IHD, however women have more adverse outcomes than men.
3. Results from the 2012 AHA survey of women's awareness of CVD:
 - 56% of white women recognized CVD as the leading cause of death - lower recognition in black and Hispanic women who are most at risk
 - About half of women in 2012 considered themselves very well/well informed about heart disease in women - but most had difficulty identifying symptoms of IHD
 - Chest pain was less frequently cited as a warning sign of a heart attack in 2012 compared with 1997 (56% versus 67%)
 - Awareness of women's less typical IHD symptoms was very low
4. Life expectancy for women is longer than for men (yielding an older population of females at risk for IHD). However, the death rate for younger women aged 35-44 years continues to increase, but is decreasing in their male counterparts. Risk factors such as diabetes mellitus, hypertension, obesity smoking and metabolic syndrome are thought to be the major causes of IHD; there is a lack of recognition of prodromal symptoms and failure to correctly assess for IHD in this younger population of women.
5. In the US, race/ethnic variations in IHD exist in prevalence and death rates. Black women have a higher prevalence rate (7.0%) compared to Hispanic women (5.9%) and white women (4.6%). As this paper indicates, by CDC statistics, the leading cause of death for black (23.4%) and white (22.9%) women is IHD, but IHD is considered the second leading cause of death for Hispanic women (20.5%), Asian/Pacific Islander women (20.8%) and American Indian/Alaska Native women (16.9%).
6. Women's experience with IHD is multifactorial and includes risk factors (RFs) such as those that are psychosocial in nature, obesity, metabolic syndrome, diabetes mellitus, dyslipidemia, physical inactivity, tobacco use, aging, and hypertension. Prevention of major cardiovascular risk factors in females should occur at an early age, starting in childhood in order to affect the trends toward younger development of IHD. Several emerging risk factors are discussed in this paper.
7. It is critical that healthcare providers assess women's risk for IHD. However, ideal risk assessment tools are needed to correctly identify those risks unique to women include the new and emerging risks discussed in this paper.
8. Studies have shown that women are less likely to experience chest pain than men, however, the majority of women will experience prodromal symptoms of IHD such as shortness of breath or unusual fatigue many weeks or months before an acute cardiac event. These prodromal symptoms are often not recognized either by the women themselves or healthcare providers. Women often delay seeking evaluation of these symptoms.
9. This scientific statement is a comprehensive overview of the prevention of IHD in women. It also discusses how women experience IHD which is different than men. Gaps in the science of IHD in women are elucidated in this paper and include: risks, mechanism and assessment of IHD, interventions of care, and symptoms. Future directions for translating science into practice and education are discussed and include: practice (education of HCPs and women, assessment of sex-specific risks history, and physical examination by all primary care providers and gynecologists and population health work in decreasing risks on women and girls.
10. Understanding the sex related differences between men and women and the potential diagnostic differences in women are important and should be considered when assessing women for IHD.

McSweeney JC, et al; on behalf of the American Heart Association Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, Council on Hypertension, Council on Lifestyle and Cardiometabolic Health, and Council on Quality of Care and Outcomes Research. [Preventing and experiencing ischemic heart disease as a woman: state of the science: a scientific statement from the American Heart Association](#) [published online ahead of print February 29, 2016]. Circulation. doi/10.1161/CIR.0000000000000381.