Cardiovascular Disease Prevention and Advanced Treatment in Women: Update on the 2011 American Heart Association (AHA) Guidelines

Objectives

- Discuss strategies to assess and stratify women into high risk, at risk, and ideal health categories for cardiovascular disease (CVD)
- Summarize lifestyle approaches to the prevention of CVD in women
- Review American Heart Association (AHA) 2011 Guidelines approaches to CVD prevention for patients with hypertension, lipid abnormalities, and diabetes, with a focus on effectiveness in practice
- Review AHA 2011 Guidelines approach to pharmacological intervention for women at risk for cardiovascular events
- Summarize commonly used therapies that should not be initiated for the prevention or treatment of CVD, because they lack benefit or because risks outweigh benefits

Coronary heart disease is the leading cause of death for all women. The following table shows deaths per 100,000. African American women have higher death rates for CHD, stroke and lung cancer than white, Hispanic or Asian women.

<table>
<thead>
<tr>
<th></th>
<th>CHD</th>
<th>Stroke</th>
<th>Lung Cancer</th>
<th>Breast Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>130.0</td>
<td>57.0</td>
<td>39.0</td>
<td>32.2</td>
</tr>
<tr>
<td>White</td>
<td>101.5</td>
<td>41.0</td>
<td>41.3</td>
<td>23.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>84.5</td>
<td>32.3</td>
<td>14.1</td>
<td>14.8</td>
</tr>
<tr>
<td>Asian</td>
<td>58.9</td>
<td>34.9</td>
<td>18.1</td>
<td>11.7</td>
</tr>
</tbody>
</table>

SOURCES:


The chart below shows the number of U.S. men and women diagnosed with myocardial infarction and fatal CHD by age. Although women in general present at later ages than men, over 10,000 reproductive age women per year are diagnosed with myocardial infarction or suffer fatal CHD.

<table>
<thead>
<tr>
<th></th>
<th>Age 35-44</th>
<th>Age 45-64</th>
<th>Age 65-74</th>
<th>Age 75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>30,000</td>
<td>265,000</td>
<td>180,000</td>
<td>235,000</td>
</tr>
<tr>
<td>Women</td>
<td>10,000</td>
<td>95,000</td>
<td>95,000</td>
<td>290,000</td>
</tr>
</tbody>
</table>

SOURCES:
The chart below shows U.S. cardiovascular disease deaths from 1980-2007. While the number of deaths in males has been steadily declining over the past 15-20 years, cardiovascular deaths for women remained flat or increased slightly during the 1980s and 1990s. The number of deaths for women has exceeded those for men over the past 20 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>487,000</td>
<td>495,000</td>
</tr>
<tr>
<td>1990</td>
<td>445,000</td>
<td>475,000</td>
</tr>
<tr>
<td>1995</td>
<td>452,000</td>
<td>503,000</td>
</tr>
<tr>
<td>2000</td>
<td>440,000</td>
<td>506,000</td>
</tr>
<tr>
<td>2007</td>
<td>391,886</td>
<td>421,918</td>
</tr>
</tbody>
</table>

SOURCES:


**Cultural Competency: Considering the Diversity of Patients**
- In addition to race/geographic/ethnic origin, other facets of diversity should be considered, including:
  - Age, language, culture, literacy, disability, frailty, socioeconomic status, occupational status, and religious affiliation
- The root causes of disparities include variations and lack of understanding of health beliefs, cultural values and preferences, and patients’ inability to communicate symptoms in a language other than their own
- Clinicians also should be familiar with patients’ socioeconomic status, which may make attaining a healthy lifestyle and using medications more difficult

SOURCE:

**Women Receive Fewer Interventions to Prevent and Treat Heart Disease**
- Less cholesterol screening
- Fewer lipid-lowering therapies
- Less use of heparin, beta-blockers and aspirin during myocardial infarction
- Less antiplatelet therapy for secondary prevention
• Fewer referrals to cardiac rehabilitation
• Fewer implantable cardioverter-defibrillators compared to men with the same recognized indications

SOURCES:


**Educate Patients About the Warning Symptoms of a Heart Attack**
- Chest pain, discomfort, pressure or squeezing are the most common symptoms for men and women
- Women are somewhat more likely than men to experience other heart attack symptoms, including:
  - Unusual upper body pain or discomfort in one or both arms, the back, shoulder, neck, jaw, or upper part of stomach
  - Shortness of breath
  - Nausea/Vomiting
  - Unusual or unexplained fatigue (which may be present for days)
  - Breaking out in a cold sweat
  - Light-headedness or sudden dizziness
- If any of these symptoms occur, call 9–1–1 for emergency medical care.

SOURCES:

The Make the Call. Don't Miss a Beat. campaign is a national public education campaign that aims to educate, engage and empower women and their families to learn the seven most common symptoms of a heart attack and encourage them to call 9-1-1 as soon as those symptoms arise.

**Encourage Patients To Make The Call. Don’t Miss a Beat**

- Only 53% of women said that they would call 9-1-1 if experiencing the symptoms of a heart attack
- However, 79% said they would call 9-1-1 if someone else was having a heart attack
- For themselves, 46% of women would do something other than call 9-1-1—such as take an aspirin, go to the hospital, or call the doctor

**SOURCES:**


The Make the Call. Don’t Miss a Beat. campaign is a national public education campaign that aims to educate, engage and empower women and their families to learn the seven most common symptoms of a heart attack and encourage them to call 9-1-1as soon as those symptoms arise.

**2011 Update: Guidelines for the Prevention of Cardiovascular Disease in Women**


**SOURCES:**


Evidence-based guidelines for the prevention of cardiovascular disease in women developed in 2004, updated in 2007, and updated again in 2011. For the original 2004 guidelines, over 1,270 articles were screened by the panel, and 400 articles were included for evidence tables. The summary evidence used by the expert panel in 2011 can be obtained online as a Data Supplement at [http://circ.ahajournals.org](http://circ.ahajournals.org).
### Classifications and Evidence

<table>
<thead>
<tr>
<th>Classification and Levels of Evidence</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>Intervention is useful and effective</td>
</tr>
<tr>
<td>Class IIa</td>
<td>Weight of evidence/opinion is in favor of usefulness/efficacy</td>
</tr>
<tr>
<td>Class IIb</td>
<td>Usefulness/efficacy is less well established by evidence/opinion</td>
</tr>
<tr>
<td>Class III</td>
<td>Procedure/test not helpful or treatment has no proven benefit</td>
</tr>
<tr>
<td></td>
<td>Procedure/test excess cost without benefit or harmful or treatment harmful to patients</td>
</tr>
</tbody>
</table>

| Level of evidence A                   | Sufficient evidence from multiple randomized trials |
| Level of evidence B                   | Limited evidence from single randomized trial or other nonrandomized studies |
| Level of evidence C                   | Based on expert opinion, case studies, or standard of care |

**SOURCE:**

**Calculate 10-Year CVD Risk using either lipids or BMI at**

**SOURCE:**
[http://www.framinghamheartstudy.org](http://www.framinghamheartstudy.org)

**Stratify Patients with the following conditions as High Risk:**
- Documented atherosclerotic disease, including
  - clinically manifest coronary heart disease,
  - clinically manifest peripheral arterial disease,
  - clinically manifest cerebrovascular disease,
  - abdominal aortic aneurysm, and
- Diabetes mellitus
- End-stage or chronic kidney disease
- 10-year Framingham cardiovascular disease risk ≥ 10% [new in 2011]

**SOURCES:**


The major change in the 2011 guidelines for the definition of “high risk patients” is to identify “high risk patients” as those at 10% or higher risk of a CVD event within 10 years. The previous definition specified a 20% or higher risk.

**Stratify Patients as At Risk if they have ≥ 1 of the following risk factors for CVD, including (but not limited to):**

- Cigarette smoking
- Hypertension: SBP ≥ 120 mm Hg, DBP ≥ 80 mm Hg or treated
- Dyslipidemia
- Family history of premature CVD in a 1st degree relative (CVD at < 55 years in a male relative, or < 65 years in a female relative)
- Obesity, especially central obesity
- Physical inactivity
- Poor diet
- Metabolic syndrome
- Advanced subclinical atherosclerosis
- Poor exercise capacity on treadmill test and/or abnormal heart rate recovery after stopping exercise
- Systemic autoimmune collagen-vascular disease (e.g. lupus, rheumatoid arthritis) [new in 2011]
- A history of pregnancy-induced hypertension, gestational diabetes, preeclampsia  [new in 2011]

**Definition of Metabolic Syndrome in Women:**

- Any 3 of the following:
  - Abdominal obesity - waist circumference ≥ 35 in.,
  - High triglycerides ≥ 150 mg/dL,
  - Low HDL cholesterol < 50 mg/dL,
  - Elevated BP ≥ 130/85 mm Hg,
  - Fasting glucose ≥ 100 mg/dL,
The metabolic syndrome is characterized by a constellation of risk factors in one individual. This syndrome increases the risk for CHD at any given LDL-cholesterol level.

This is the American Heart Association/National Heart, Lung, and Blood Institute definition of metabolic syndrome. Patients are diagnosed with metabolic syndrome when three of five criteria are met. Patients receiving drug treatment for elevated triglycerides, reduced HDL, hypertension, or high glucose meet the threshold for each criteria. A cutoff of 31 inches waist circumference for Asian American women should be used.

Common Diagnoses in Ob/Gyn that increase lifetime CVD risk, include pregnancy-induced hypertension, gestational diabetes, polycystic ovary syndrome.

Relative risk of subsequent cardiovascular disease:
- Gestational diabetes: 1.71
- Preeclampsia: 1.74
- Polycystic Ovary Syndrome (PCOS): 1.70

SOURCES:

Stratify patients as having Ideal Cardiovascular Health if they meet the following conditions:
- Total cholesterol < 200mg/dL
- BP < 120/<80 mm Hg untreated
- Fasting blood sugar < 100 mg/dL untreated,
- Body mass index < 25 kg/m^2
- Abstinence from smoking (never or quit > 12 months)
- Physical activity at goal
- DASH (“Dietary Approaches to Stop Hypertension”)-like diet

Ideal patients are rare in most clinical practices, making up less than 5% of women in most studies

SOURCES:


Using Framingham data, only 4.5% of women in a study published in 2006 were at optimal risk (3). In a study of 24,444 postmenopausal women in Sweden after 6.2 yr follow-up, only 5% of women had all 5 measures of healthy behavior (healthy diet, moderate alcohol, physical activity, maintaining a normal weight, and not smoking), but this was associated with a 77% lower risk of MI (4).

**Other Lifestyle Interventions**
- Smoking cessation
- Physical activity
- Weight reduction/maintenance
- Heart healthy diet
- Depression
- Omega-3 fatty acids
- Cardiac rehabilitation

**SOURCE:**

These are the Class I lifestyle recommendations applicable to all women.

**Smoking Cessation**
- All women should be consistently encouraged to stop smoking and avoid environmental tobacco
  - Women face barriers to quitting
    - Concomitant depression
    - Concerns about weight gain
  - Encourage women who stop smoking while pregnant to continue abstinence postpartum
- Provide counseling, nicotine replacement, and other pharmacotherapy as indicated in conjunction with a behavioral program or other formal smoking cessation program
- 1-800-QUIT-NOW- free phone counseling and/or written materials
- ACOG recommends consideration of risks vs. benefits when considering the use of nicotine replacement or bupropion for smoking cessation in pregnant women however, no pharmacological therapies are FDA-approved for use during pregnancy.
SOURCES:


Smoking Cessation: FDA-approved pharmacotherapy
- Nicotine replacement therapy
  - Patch
  - Gum
  - Lozenge
  - Inhaler
- Bupropion
- Varenicline

ACOG recommends consideration of risks vs. benefits when considering the use of nicotine replacement or bupropion for smoking cessation in pregnant women however, no pharmacological therapies are FDA-approved for use during pregnancy.

SOURCES:


Physical Activity
- Consistently encourage the following:
  - Moderate Exercise – 150 minutes per week, OR
  - Vigorous Exercise – 75 minutes per week, OR
  - An equivalent combination of the two
- Aerobic exercise should be performed in episodes of at least 10 minutes, preferably spread throughout the week
- Muscle strengthening activities that involve all major muscle groups should be performed 2 or more days/week
- Moderate Exercise includes:
  - Dancing fast for 30 minutes
  - Raking leaves for 30 minutes
  - Gardening for 30-45 minutes
  - Pushing a stroller 1 mile in 30 minutes
Women who need to lose weight or sustain weight loss should accumulate a minimum of 60-90 minutes of moderate-intensity physical activity on most, and preferably all, days of the week.

**SOURCES:**


Examples of moderate amounts of physical activity:

**Common Chores**
- Washing and waxing a car for 45-60 minutes
- Washing windows or floors for 45-60 minutes
- Gardening for 30-45 minutes
- Wheeling self in wheelchair 30-40 minutes
- Pushing a stroller 1-1/2 miles in 30 minutes
- Raking leaves for 30 minutes
- Walking 2 miles in 30 minutes (15 min/mile)
- Shoveling snow for 15 minutes
- Stairwalking for 15 minutes

**Sporting Activities**
- Playing volleyball for 45-60 minutes
- Playing touch football for 45 minutes
- Walking 1-3/4 miles in 35 minutes (20 min/mile)
- Basketball (shooting baskets) 30 minutes
- Bicycling 5 miles in 30 minutes
- Dancing fast (social) for 30 minutes
- Water aerobics for 30 minutes
- Swimming laps for 20 minutes
- Basketball (playing game) for 15-20 minutes
- Bicycling 4 miles in 15 minutes
- Jumping rope for 15 minutes
- Running 1-1/2 miles in 15 min. (10 min/mile)

**Body Weight and CHD Mortality Among Women**

- The participants in this part of the Nurses Health Study were 115,195 women free of diagnosed cardiovascular disease and cancer in 1976, who were followed until 1992.
- The lowest mortality was seen in women who weighed at least 15% less than the U.S. average, and among those whose weight had been stable since early adulthood.
- Weight gain of 20 kg or more since the age of 18 confers a greater than 7 times relative risk of CHD mortality.

**SOURCE:**

The participants in this part of the Nurses Health Study were 115,195 women free of diagnosed cardiovascular disease and cancer in 1976, who were followed until 1992 (1). This graph demonstrates mortality among non-smoking women at various BMI levels.

The lowest mortality was seen in women who weighed at least 15% less than the U.S. average, and among those whose weight had been stable since early adulthood (1).

**Weight Maintenance/Reduction Goals**
- Women should maintain or lose weight through an appropriate balance of physical activity, calorie intake, and formal behavioral programs when indicated to maintain:
  - BMI between 18.5 and 24.9 kg/m²
  - Waist circumference ≤ 35 inches
- Women can obtain a dietary plan customized to their BMI and level of physical activity at: http://www.mypyramid.gov

**SOURCE:**

**Low Risk Diet is Associated with Lower Risk of Myocardial Infarction in Women**
- In a population-based prospective cohort study of 24,444 postmenopausal women in Sweden, after 6.2 years of follow-up, a low risk diet characterized by a high intake of vegetables, fruit, whole grains, fish, and legumes, as well as moderate alcohol consumption, physical activity, maintaining a healthy weight, and not smoking were associated with lower risk of myocardial infarction. A combination of all healthy behaviors was predicted to prevent 77% of myocardial infarctions in the study population. In this study, only 5% of women had all healthy behaviors.
- AHA recommends women consume one or fewer alcoholic beverages a day.

**SOURCE:**

**Consistently Encourage Health Eating Patterns**
- Healthy food selections:
  - Fruits and vegetables (1 serving = 1 cup raw leafy vegetable, 1/2 cup cut-up raw or 1 medium fruit)
  - Whole grains, high fiber (1 serving = 1 slice bread, 1 oz. dry cereal, or 1/2 cup cooked rice, pasta, or cereal (all whole-grain))
  - Fish, especially oily fish, at least twice per week (1 serving = 3.5 oz. cooked)
  - No more than one drink of alcohol per day
  - Less than 1500mg of sodium per day
- Saturated fats < 7% of calories, < 150 mg cholesterol
- Limit sugar and trans fatty acid intake (main dietary sources are baked goods and fried foods made with partially hydrogenated vegetable oil)
• Pregnant women should be counseled to avoid eating fish with the potential for the highest level of mercury contamination (e.g., shark, swordfish, king mackerel or tilefish)

SOURCES:


Trans-fatty acids are found in hydrogenated vegetable oils and some animal fats (1).

Major sources are baked foods like crackers, cookies, doughnuts, breads, and food fried in hydrogenated vegetable oil, like French fries and fried chicken (1).

Based on data from randomized trials, trans-fatty acids raise LDL cholesterol (1).

**Psychosocial Stressors in Women with Coronary Heart Disease (CHD): The Stockholm Female Coronary Risk Study**

• Among women who were married or cohabitating with a male partner, marital stress was associated with nearly 3-fold increased risk of recurrent CHD events
• Living alone and work stress did not significantly increase recurrent CHD events

SOURCE:

**Depression and CVD**

• Depression is an independent predictor of CHD death among women with no history of CHD
• Screening and treatment for depression has not been shown to improve clinical outcomes, however,
• Depression may reduce adherence to CVD medications, therefore, screening is recommended for women with CVD

SOURCES:


Recently, an arm of the Women’s Health Initiative reported findings on depression in 93,676 women with no baseline history of CHD. After an average of 4.1 years of follow-up, depression was an independent predictor of CHD death and all-cause mortality after adjustment for age, race, education, income, DM, HTN, smoking, body mass index, physical activity and increased cholesterol (1).

Whether identification and treatment of depression will lower CHD risk is unknown (1).

**Omega-3 Fatty Acids**
- Consumption of omega-3 fatty acids in the form of fish or in capsule form (e.g., EPA 1800mg/day) may be considered in women with hypercholesterolemia and/or hypertriglyceridemia for primary and secondary prevention (Class IIb; Level of Evidence B)
- Fish oil dietary supplements may have widely variable amounts of EPA and DHA (likely the only active ingredients)

**SOURCES:**


Omega-3 polyunsaturated fatty acids are found in certain vegetable sources, as well as in fish oils (1). Clinical trials incorporating increased intake of omega-3 polyunsaturated acids as fatty fish, components of a “Mediterranean” diet, or fish oil capsules suggest that omega-3 fatty acids reduce sudden death and overall death in persons with coronary artery disease (1).

High intake of omega-3 fatty acids can cause excessive bleeding. Some types of fish can contain methylmercury, dioxin, and other environmental toxins (2).

**Cardiac Rehabilitation**
- A comprehensive risk reduction regimen should be recommended to women with recent acute coronary syndrome or coronary intervention, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease, or current/prior symptoms of heart failure and a Left Ventricular Ejection Fraction (LVEF) < 35%
- Risk reduction regimens may include:
  - Cardiac or stroke rehabilitation
  - Physician-guided home or community-based exercise training programs

**SOURCE:**

**Major Risk Factor Interventions**

- **Blood Pressure**
  - Target BP < 120/80 mm Hg
  - Pharmacotherapy if BP ≥ 140/90 mm Hg, or ≥ 130/80 mm Hg in diabetics or patients with renal disease
    - ACE inhibitors are contraindicated in pregnancy and ought to be used with caution in women who may become pregnant

- **Lipids**
  - Follow NCEP/ATP III guidelines

- **Diabetes**
  - Target HbA1C < 7%, if this can be accomplished without significant hypoglycemia

**SOURCE:**

**Hypertension:**

- The average of two seated blood pressure measurements should guide care
  - If BP > 180/110 mm Hg, evaluate and treat immediately or within one week depending on the clinical situation
  - If BP > 160/100 mm Hg, evaluate and treat or refer within one month
  - If BP ≥ 140/90 mm Hg, recheck within 2 months, if confirmed, evaluate and treat or refer
  - If BP ≥ 120/80 mm Hg, counsel regarding lifestyle factors, recheck within one year and monitor

- Initial evaluation of the hypertensive patient should include 12-lead EKG, urinalysis, hematocrit, serum glucose, creatinine, calcium, and potassium measurement, and a lipid profile.

- Encourage an optimal blood pressure of <120/80 mm Hg through lifestyle approaches

- Pharmacologic therapy is indicated when blood pressure is ≥ 140/90 mm Hg or an even lower blood pressure in the setting of diabetes or target-organ damage (≥ 130/80 mm Hg)

- Thiazide diuretics should be part of the drug regimen for most patients unless contraindicated, or unless compelling indications exist for other agents

- For high risk women, initial treatment should be with a beta-blocker or angiotensin converting enzyme inhibitor or angiotensin receptor blocker

**SOURCES:**
Lifestyle Approaches to Reduce Hypertension in Women

- Maintain ideal body weight
  - Weight loss of as little as 10 lbs. reduces blood pressure
- Dietary Approaches to Stop Hypertension (DASH) eating plan (low sodium)
  - Even without weight loss, a low fat diet that is rich in fruits, vegetables, and low fat dairy products can reduce blood pressure
- Sodium restriction to 1500 mg per day may be beneficial, especially in African American patients
- Increase physical activity
- Limit alcohol to one drink per day
  - Alcohol raises blood pressure
  - One drink = 12 oz. beer, 5 oz. wine, or 1.5 oz. liquor

SOURCES:


Lipids: Targets

- Optimal levels of lipids and lipoproteins in women are as follows (these should be encouraged in all women with lifestyle approaches):
  - LDL-C < 100 mg/dL
  - HDL-C > 50 mg/dL
  - Triglycerides < 150 mg/dL
  - Non-HDL-C < 130 mg/dL (Non-HDL equals total cholesterol minus HDL)

SOURCE:
Treatable Risk Factors: The Epidemiology of Cholesterol Levels and Subfractions

- Low HDL-C more important in women than men
  - For every 1 mg/dL increase in HDL-C 3% decrease in CHD risk for women and 2% decrease in CHD risk for men
- Triglyceride elevation associated with greater atherogenic significance in women than in men

SOURCE:

Treatable Risk Factors: Cholesterol Level and Subfractions

- LDL-C > 160 mg/dL associated with 3.3-fold elevation in risk for women less than 65 years old
- LDL-C pattern of small, dense particles (more atherogenic) present in 25% of population, but less frequently seen in women
- Menopausal transition associated with increasing proportion of this subfraction

SOURCES:


Lipids

- LDL-C-lowering drug therapy is recommended simultaneously with lifestyle therapy in women with CHD to achieve an LDL-C < 100 mg/dL and is also indicated in women with other atherosclerotic CVD or diabetes mellitus or 10-year absolute CHD risk >20%
- A reduction to < 70 mg/dL is reasonable in very-high-risk women (e.g., those with recent ACS or multiple poorly controlled cardiovascular risk factors) with CHD and may require an LDL-C-lowering drug combination

SOURCE:

High-Sensitivity C-Reactive Protein (hsCRP)

- hsCRP should not be used for routine screening of all women, but should be reserved for refining risk estimates in intermediate risk patients when there is uncertainty regarding the need to start drug therapy
• Consider statins in women over 60 years of age if, after lifestyle modification, hsCRP remains elevated above 2 mg/dL and no acute inflammatory process is present (Class IIb; Level of Evidence B)

**SOURCES:**


The role that novel CVD risk biomarkers (e.g., hsCRP or advanced lipid testing) and imaging technologies (e.g., coronary calcium scoring assessment) should play in risk assessment and in delineation of appropriate preventive interventions is not yet well-defined. It should be noted that JUPITER did not test a strategy of routine screening with hsCRP to determine benefit of statin therapy, because those with lower hsCRP levels were not studied (2).

These approaches should not be used for routine screening of all women. Instead, the American Heart Association and other national groups have recommended that the use of these novel modalities should be reserved for refining risk estimates in intermediate risk patients (defined either as 10% to 20% or 6% to 20% 10-year risk) when there is uncertainty regarding the need to start drug therapy.

**2004 Update of Adult Treatment Panel (ATP) III**
• 5 recent clinical trials suggest added benefit of optional lowering of cholesterol more than ATP III recommended
• Lifestyle changes remain cornerstone of treatment
• Advises that intensity of LDL-C-lowering drug treatment in high-risk and moderately high-risk patients achieve at least 30% reduction in LDL-C levels

**SOURCE:**

In July, 2004, some elements of the Adult Treatment Panel III were revisited, based on the completion of five clinical trials of cholesterol-lowering statin treatment that have been conducted since the release of the previous guidelines (1).

Lifestyle changes are still emphasized, including the adoption of a low saturated fat and low cholesterol diet, increased physical activity and weight control (1).

The update offers options for more intensive lowering of cholesterol levels for people at very high risk (1).
Adult Treatment Panel (ATP) III Guidelines for Statin Therapy: Very High Risk Women

- Those with recent ACS or multiple poorly controlled CV risk factors
- Recent heart attack or known CAD, along with one or more of the following:
  - Multiple major risk factors, particularly in diabetics
  - Severe or poorly controlled risk factors (i.e., continued smoking)
  - Multiple risk factors of the metabolic syndrome, especially
    TG ≥ 200 mg/dL AND HDL-C < 40 mg/dL
- LDL-C goal of < 100 mg/dL
- Consider statin, even if LDL-C < 100 mg/dL
- Optional LDL-C goal of < 70 mg/dL per ATP III 2004 update

SOURCE:

A new category of “very high risk” was added in the update to ATP III in 2004 (1). ATP III was updated based on the publication of five major clinical trials of statin therapy (1).

For women determined to be in this “very-high risk” category lowering the LDL cholesterol to less than 100mg/dl, and as low as 70 mg/dl, may be considered (1).

Adult Treatment Panel (ATP) III Guidelines for Statin Therapy: High Risk Women

- ≥ 20% 10-year risk of CHD
- CHD, large vessel atherosclerotic disease, DM
- Goal LDL-C < 100 mg/dL, consider statin even if LDL-C < 100 mg/dL

SOURCE:

Adult Treatment Panel (ATP) III Guidelines for Statin Therapy: Multiple or Severe Risk Factors, 10-20% 10-Year CHD Risk

- Initiate drug therapy if LDL-C ≥ 130 mg/dL after lifestyle therapy
- Consider drug therapy if LDL-C ≥ 100 mg/dL after lifestyle therapy
- Goal LDL-C < 100 mg/dL


SOURCES:

Adult Treatment Panel (ATP) III Guidelines for Statin Therapy: Multiple Risk Factors, 10-Year CHD Risk < 10%

- Initiate drug therapy if LDL-C ≥ 160 mg/dL after lifestyle therapy

Framingham 10-year CHD Risk Calculator available at:
http://www.framinghamheartstudy.org/risk/coronary.html

SOURCES:


Adult Treatment Panel (ATP) III Guidelines for Statin Therapy: No Other Risk Factors, 10-Year CHD Risk < 10%

- Initiate drug therapy if LDL-C ≥ 190 mg/dL after lifestyle therapy
- Drug therapy optional for LDL-C = 160-189 mg/dL after lifestyle therapy

Framingham 10-year CHD Risk Calculator available at:
http://www.framinghamheartstudy.org/risk/coronary.html

SOURCES:


Coronary Disease Mortality and Diabetes in Women

- In a study of 116,000 subjects, aged 30-55, who were followed for 8 years, the risk of nonfatal and fatal CHD was > 6-fold that of women without diabetes
- Risks for all forms of CVD are elevated in women with type 1 and type 2 diabetes
- Women with diabetes with CHD are more likely to die than women without diabetes with CHD

SOURCES:


Race/Ethnicity and Diabetes

• At elevated risk:
  ○ Latinas
  ○ American Indians
  ○ African Americans
  ○ Asian Americans
  ○ Pacific Islanders

SOURCE:

Preventive Drug Interventions: Aspirin

• High Risk Women:
  ○ Aspirin therapy (75 to 325 mg/d) should be used in women with CHD unless contraindicated
  ○ Aspirin therapy (75 to 325 mg/d) is reasonable in women with diabetes mellitus unless contraindicated
  ○ If a high-risk woman has an indication but is intolerant of aspirin therapy, clopidogrel should be substituted

• Other at-risk or healthy women:
  ○ Aspirin therapy can be useful in women ≥ 65 years of age, (81mg daily or 100mg every other day) if blood pressure is controlled and benefit for ischemic stroke and MI prevention is likely to outweigh risk of gastrointestinal bleeding and hemorrhagic stroke and may be reasonable for women < 65 years for ischemic stroke prevention

SOURCE:

Interventions that are not useful/effective and may be harmful for the prevention of heart disease

• The following should not be used for the primary or secondary prevention of CVD:
  ○ Antioxidant supplements and folic acid supplements
    • No cardiovascular benefit in randomized trials of primary and secondary prevention
    • Folic acid 0.4mg daily is recommended for reproductive aged women who may get pregnant to prevent neural tube defects
  ○ Selective estrogen-receptor modulators (SERMs)
  ○ Hormone therapy for menopause

SOURCES:


The Women’s Health Study, a 10-year randomized double-blind, placebo controlled trial of nearly 40,000 healthy women aged 45 years and older showed no cardiovascular benefit or risk to vitamin E supplementation (600 IU every other day) (1). The HOPE and HOPE-TOO trials performed in patients with CHD equivalent risk also found no benefit (2).

Multiple trials have shown no CHD benefit or a trend to harm for folic acid supplementation in patients with coronary artery disease or significant CHD risk (3), (4).

**What the Experts are Saying About Hormone Therapy and Cardiovascular Disease**

- NIH – “New analyses from the Women’s Health Initiative (WHI) confirm that combination hormone therapy increases the risk of heart disease in healthy postmenopausal women. Researchers report a trend toward an increased risk of heart disease during the first two years of hormone therapy among women who began therapy within 10 years of menopause.”
  - From the “WHI Study Data Confirm Short-Term Heart Disease Risks of Combination Hormone Therapy for Postmenopausal Women,” *NIH News*, Monday, February 15, 2010

**Prevention of Cardiovascular Disease in Women**

- Stratify women into high, at risk, and ideal risk categories
- Encourage lifestyle approaches
- Treat hypertension, lipid abnormalities, and diabetes
• Implement pharmacologic interventions for women at high and intermediate risk; pharmacologic interventions may be appropriate for some lower risk women
• Avoid initiating therapies without benefit, or where risks outweigh benefits

SOURCE:

The Heart Truth Professional Education Campaign Website
www.womenshealth.gov/heart-truth

Million Hearts Campaign Website
millionhearts.hhs.gov
“Get involved and share your commitment to help prevent 1 million heart attacks and strokes in the next five years.”