

HEART DISEASE IN WOMEN A LOOK AT SOME MAJOR STUDIES

New data leads the way

Atherosclerosis is the leading cause of death in males and females; the major difference is that women usually present 10 years later and 50% of them will die from cardiovascular complications.

New data on hormone replacement therapy (HRT), angiotensin-converting enzyme (ACE) inhibitors, and statins have changed how physicians look at cardiovascular disease (CVD) prevention in females. Results from large, randomised, controlled trials should guide physicians in their clinical practices.

Is HRT preventive?

In the past, HRT was believed to be a cardiovascular protective treatment. Then, a series of randomised, controlled trials demonstrated the opposite effects.

In 1998, Heart and Estrogen/Progestin Replacement Study (HERS) included close to

3,000 women with established heart disease at a mean age of 67. They were randomised to conjugated estrogen tablets (Premarin®) and medroxyprogesterone acetate (Provera®) on a continuous basis versus placebo.¹ The therapy showed a good lipid effect, however over a period of four years no cardiovascular protection was seen.¹

Most recently, the Women's Health Initiative, which randomised patients to oral estrogen and medroxyprogesterone acetate, was stopped due to increase incidence of stroke, myocardial infarction (MI), deep venous thrombosis, pulmonary emboli, and breast cancer.²

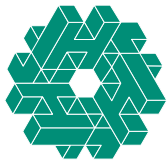
Is there HOPE?

Heart disease is the number one cause of death in women in Canada and, along with stroke, kills eight times more women than breast cancer. Also, women with heart problems are more likely to have other health problems, such as high blood pressure and diabetes. The Heart

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Outcomes Prevention Evaluation (HOPE) study set out to identify preventive strategies for women.

The objective of one of HOPE's sub-studies was to disprove the suggestion that angiotensin converting enzyme (ACE) inhibitors are less effective in treating CVD in women than they are in men.

The sub-study included 2,480 women, 55 or older, with established CVD or diabetes and additional risk factors, such as family history of CVD, a weight problem, and smoking. The patients were randomised to receive ramipril, 10 mg, once daily or a matching placebo. Followup visits occurred at one month and six months after randomisation, and then every six months to the remainder of the study for an average of 4.5 years.³

The study found that the effect of ramipril in reducing cardiovascular risk in women was just as high as in men, even after adjusting for baseline imbalances. There was a 38% reduction in the risk of cardiovascular death, a 36% reduction in the risk of stroke and a 23% reduction in the risk of MI, stroke or cardiovascular death combined. The risk of worsening angina was also significantly reduced.³

Can statins help?

The Heart Protection Study (HPS) involved just over 20,000 individuals of ages 40 to 80 with

cholesterol > 3.5 mmol/dL and at high risk for atherosclerosis progression. Simvastatin, 40 mg, was used.⁴


This was the largest randomised, clinical trial done with statin therapy and it showed benefit and safety in both males and females. The results proved that females around age 50 should have a full lipid profile and should be treated according

to the Canadian Consensus Guidelines.⁴ Women who have diabetes or CVD should be treated aggressively.

A recent study showed HRT to increase the incidence of stroke, MI, deep venous thrombosis, pulmonary emboli, and breast cancer.

Physician's Perspective

New data from large, randomised, controlled trials have added to the body of knowledge on prevention of heart disease in women.

While HRT is under a cloud of smoke, there are other options to help improve the health status of the aging female population. The HPS demonstrated a benefit of lipid management in over 5,000 women, and insights from the HOPE study demonstrated benefit in reducing future cardiovascular events with the use of ACE inhibitors, such as ramipril. 

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