# New Guidelines Focus on Heart Disease in Women

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The American Heart Association's new evidence-based guidelines for preventing cardiovascular disease in women emphasize a woman's lifetime risk and provide new recommendations on aspirin, folic acid, antioxidant therapy, and hormone therapy.

The updated guidelines are the most current clinical recommendations for preventing cardiovascular disease (CVD) in women aged 20 and older, addressing the primary and secondary prevention of chronic atherosclerotic vascular diseases. The recommendations are based on "a systematic search of the highest quality science, interpreted by experts in the fields of cardiology, epidemiology, family medicine, gynecology, internal medicine, neurology, nursing, public health, statistics, and surgery," according to the authors, an expert panel. The guidelines will be published in the March 20 issue of Circulation.

The new guidelines place a greater emphasis on a woman's lifetime risk of CVD, rather than on the short-term risk, as in the previous guidelines, issued in 2004. The panel acknowledged that nearly all women are at risk for CVD, a fact that "underscores the importance of a heart-healthy lifestyle." Instead of classifying a woman as being at high, intermediate, lower, or optimal risk, the 2007 guidelines recommend classifying a woman as high risk, at risk, or optimal risk.

Part of the rationale for emphasizing lifetime risk rather than short-term risk is evidence that physicians do not make strong lifestyle recommendations for women considered low risk, said Dr. Lori Mosca, the chair of the expert panel that wrote the new guidelines. Helping women understand—even though their short-term risk may not be impressive—that because heart disease and stroke are such common conditions, "many risk factors can be prevented by doctors [if they stress] a more aggressive lifestyle [intervention] early on," she said in an interview, noting that 30% of women have CVD and almost one in three women dies of it.

For example, as women age, they tend to gain weight with every decade, increasing their risk for hypertension, abnormal cholesterol levels, and diabetes. "If we can communicate effectively with our patients that healthy lifestyles early on will prevent the development of risk factors requiring treatment … this may be very motivational for patients," said Dr. Mosca, director of preventive cardiology at New York–Presbyterian Hospital.

She urged physicians to link positive behaviors with outcomes that are meaningful to the patient. "What doctors can do is help women understand that their behaviors now will make a difference even in their midlife, in terms of preventing risk factors, and later in life, preventing heart disease and stroke," she said.

Other important differences from 2004 are the revisions regarding menopausal therapy, aspirin therapy, and folic acid, because more definitive data on these therapies have been published since that time. The guidelines state that hormone therapy and selective estrogen receptor modulation should not be used for primary or secondary prevention of CVD in women and that antioxidant supplements, such as β-carotene and vitamins E and C, should not be used. Folic acid, with or without vitamin $B_6$ and $B_{12}$ supplementation, should also not be used to prevent CVD.

More definitive clinical trial data are now available regarding the use of aspirin in women to prevent stroke, and the new guidelines say that "aspirin therapy should be considered for all women for stroke prevention, depending on the balance of risks and benefits." This area is potentially a confusing one for physicians, Dr. Mosca said. The strengths of these recommendations are classified based on the levels of evidence available.

For high-risk women, aspirin therapy at 75-325 mg/day is recommended unless contraindicated, in which case clopidogrel should be substituted. The recommendation for aspirin for high-risk women—such as women with diabetes or heart disease—is class I, where the intervention is considered useful and effective and should be done unless there is a reason not to, Dr. Mosca said. For other at-risk or healthy women aged 65 and older, aspirin therapy at 81 or 100 mg every other day should be considered if their blood pressure is controlled "and benefit for ischemic stroke and MI prevention is likely to outweigh" the risk of GI bleeding and hemorrhagic

stroke. This regimen should also be considered in women under age 65 when the benefit for preventing ischemic stroke is likely to outweigh the risks of treatment.

For women over 65, this is a class IIa, level B recommendation, where the intervention may prevent heart disease and stroke, but the benefits should outweigh the risks, she said. For women under 65, the evidence is very weak for stroke prevention. "It doesn't mean you can't do it … but for the majority of women under 65, the benefits of aspirin are not likely to outweigh the risks," Dr. Mosca said in the interview. Routine use of aspirin in healthy women under age 65 should also not be used to prevent MI, with evidence that is class III. (The intervention is not useful or effective and may be harmful.)

An algorithm that health care providers can use to evaluate a woman's CVD risk and to prioritize preventive interventions is provided in the guidelines, as well as a list of the evidence-based clinical recommendations for preventing CVD in women, with lifestyle interventions, major risk factor interventions, and preventive drug interventions. Each recommendation also comes with the strength of the recommendation and the evidence used to support the recommendation. A table listing interventions that, based on current evidence, are not useful or effective and may be harmful for preventing CVD or MI in women is also incorporated.

The statement refers to a previous AHA study, which found that 36% of women did not perceive themselves to be at risk for CVD and 25% said their health care provider "did not say heart health was important." And one in five "said their health care providers did not clearly explain how they could change their risk status."

Other recommendations include advising women who need to lose weight or sustain weight loss to engage in moderate-intensity physical activity for 60-90 minutes on most but preferably all days of the week.

More research on the added benefits, risks, and costs of new CVD risk factors, such as high-sensitivity C-reactive protein, and new screening techniques, such as coronary calcium scoring, is needed before they can be incorporated into these guidelines, according to the panel.

Members of the panel represented organizations and cosponsors including the AHA, American College of Physicians, American College of Cardiology Foundation, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, Centers for Disease Control and Prevention, and National Heart, Lung, and Blood Institute. ■