Cardiovascular Risk Factors in Middle Age Linked to Hypertension in Pregnancy

Risk factor	Prevalence or average level in women who were: Hypertensive in pregnancy (n = 643)	Normotensive in pregnancy (n = 3,421)
Microalbuminuria	17%	12%
Ankle-brachial index <0.9	11%	8%
Left ventricular hypertrophy	19%	13%
Serum C-reactive protein	0.46 mg/dL	0.34 mg/dL
Serum homocysteine	9.5 micromol/L	9.2 micromol/L

Note: All differences between the two study groups are statistically significant.
Source: Dr. Garovic

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that lasted longer than 6 months (this third group was not included in the analysis). The key index event was hypertension in pregnancy and not preeclampsia because the researchers who ran the Family Blood Pressure Program collected data only on hypertension during pregnancy and not information on the incidence of proteinuria or edema during pregnancy.

The women's median age was 54 years when their clinical data were collected, and cardiovascular events were only counted if they first occurred after age 39.

The cumulative incidence of stroke among the women who had hypertension in pregnancy was 5.2%, compared with 2.7% among those who were normotensive in pregnancy, a significant difference. The rate of coronary heart disease was 6.8% among those with a history of hypertension during pregnancy, compared with 5.4% among those without this background, also a significant difference.

The prevalence rates of several risk factors for cardiovascular disease were significantly greater in the women with a history of hypertension in pregnancy compared with those who had no such history, even after controlling for possible confounding factors. (See table.)

The prevalence of hypertension at the time of data collection was 61% among women with a history of hypertension in pregnancy, compared with 57% among those without this history. More notably, the average age of hypertension onset was 52 years for the women who had hypertension in pregnancy, compared with 60 years for those who did not.

Women who develop hypertension in pregnancy may have underlying endothelial dysfunction. Pregnancy may serve as a physiologic "stress test" that transiently unmasks the condition, and the disorder and its consequences become more overt again later in life. Alternatively, in predisposed women, pregnancy itself may trigger endothelial dysfunction and this later leads to other disorders, Dr. Garovic said. ■

Gender Disparity In Management Of Lipids Persists

CHICAGO — The gender gap in lipid management hasn't narrowed at all despite the March 2004 publication of American Heart Association evidence-based guidelines for prevention of cardiovascular disease in women, Dr. Lori Mosca reported at the annual scientific sessions of the AHA.

The percentage of high-risk women in two large southeastern health plans who attained an LDL cholesterol level below 100 mg/dL rose from 33% before release of the gender-specific guidelines to 40% afterward. The proportion of high-risk men with an LDL cholesterol level below 100 mg/dL climbed from 41% to 50%. So the absolute difference in rates of good lipid control between men and women—the gender gap—actually increased from 8% prior to release of the AHA guidelines to 10% afterward, according to Dr. Mosca, director of preventive cardiology at New York–Presbyterian Hospital. Clearly these data indicate lipid control remains suboptimal in both sexes, she added, since half of high-risk men and 60% of high-risk women had LDL cholesterol values in excess of the National Cholesterol Education Program (NCEP) target of 100 mg/dL.

Dr. Mosca's retrospective study utilized administrative claims data for 17,070 men and 17,357 women. All patients were high risk because they had known cardiovascular disease or diabetes.

—Bruce Jancin