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## **Updated guidelines advise focusing on women's lifetime heart risk**

*Update gives definitive answers on HRT, aspirin, supplements*

DALLAS, Feb. 20, 2007 – Healthcare professionals should focus on women’s lifetime heart disease risk, not just short-term risk, according to updated American Heart Association guidelines.

The 2007 Guidelines for Preventing Cardiovascular Disease in Women – published today in a special women’s health issue of *Circulation: Journal of the American Heart Association* – also include new directions for using aspirin, hormone therapy and vitamin and mineral supplements in heart disease and stroke prevention in women.

“The updated guidelines emphasize the lifetime risk of women, not just the more short-term focus of the 2004 guidelines,” said Lori Mosca, M.D., Ph.D., director of preventive cardiology at New York–Presbyterian Hospital and chair of the American Heart Association expert panel that wrote the guidelines. “We took a long-term view of heart disease prevention because the lifetime risk of dying of cardiovascular disease (CVD) is nearly one in three for women. This underscores the importance of healthy lifestyles in women of all ages to reduce the long-term risk of heart and blood vessel diseases.”

The guidelines include a new paradigm for risk assessment based on risk factors and family history, as well as the Framingham risk score. (First published in 1998, the Framingham risk score estimates the risk of developing coronary heart disease within 10 years.)

The new guidelines include expanded recommendations on lifestyle factors such as physical activity, nutrition and smoking cessation, as well as more in-depth recommendations on drug treatments for blood pressure and cholesterol control.

Furthermore, guidelines on hormone and aspirin therapy and antioxidant and folic acid supplements are revised based on recently published data.

“Since the last guidelines were developed, more definitive clinical trials became available to suggest that healthcare providers should consider aspirin in women to prevent stroke,” Mosca said. “In addition, providers should not use menopausal therapies such as hormone replacement therapy (HRT) or selective estrogen receptor modulators (SERMs)

such as raloxifene or tamoxifene to prevent heart disease because they have been shown to be ineffective in protecting the heart and may increase the risk of stroke.”

A recent American Heart Association survey showed that women are confused about methods to prevent heart disease including the role of aspirin, hormones and dietary supplements.

“The new guidelines reinforce that unregulated dietary supplements are not a method proven to prevent heart disease. For example, recent studies have shown that folic acid is ineffective to protect the heart despite widespread use by patients and physicians hoping for a heart benefit,” Mosca said. “These recent findings emphasize the importance of using well-conducted clinical trial data to develop national recommendations to help patients and their doctors use best practices to prevent heart disease – practices based on data rather than myth or wishful thinking.”

CVD is the largest single cause of mortality among women, accounting for 38 percent of all deaths among females. The public health impact of CVD in women is not solely related to mortality, as advances in science and medicine allow many women to survive heart disease. For example, in the United States 42.1 million (36.6 percent) women live with CVD and the population at risk is even larger.

In fact, “nearly all women are at risk for CVD, underscoring the importance of a heart-healthy lifestyle in everyone,” the authors wrote. “Some women are at significant risk of future heart attack or stroke because they already have CVD and/or multiple risk factors. These women are candidates for more aggressive preventive therapy and we define them as high risk.”

Physicians can easily identify high-risk women, but tools to determine other levels of risk are limited, Mosca said. The authors have aligned their recommendations with treatments proven to work and give strong advice for what not to do, as well.

“Therefore, we have more aggressive recommendations for high-risk women, and strongly emphasize lifestyle strategies to reduce risk in all women,” she said. “Medicine is still an art but these guidelines are meant to guide healthcare professionals on the best science available.”

Highlights of the changes include:

- Recommended lifestyle changes to help manage blood pressure include weight control, increased physical activity, alcohol moderation, sodium restriction, and an emphasis on eating fresh fruits, vegetables and low-fat dairy products.
- Besides advising women to quit smoking, the 2007 guidelines recommend counseling, nicotine replacement or other forms of smoking cessation therapy.
- Physical activity recommendations for women who need to lose weight or sustain weight loss have been added – minimum of 60–90 minutes of moderate-intensity activity (e.g., brisk walking) on most, and preferably all, days of the week.

- The guidelines now encourage all women to reduce saturated fats intake to less than 7 percent of calories if possible.
- Specific guidance on omega-3 fatty acid intake and supplementation recommends eating oily fish at least twice a week, and consider taking a capsule supplement of 850–1000 mg of EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid) in women with heart disease, two to four grams for women with high triglycerides.
- Hormone replacement therapy and selective estrogen receptor modulators (SERMs) are not recommended to prevent heart disease in women.
- Antioxidant supplements (such as vitamin E, C and beta-carotene) should not be used for primary or secondary prevention of CVD.
- Folic acid should not be used to prevent CVD – a change from the 2004 guidelines that did recommend it be considered for use in certain high-risk women.
- Routine low dose aspirin therapy may be considered in women age 65 or older regardless of CVD risk status, if benefits are likely to outweigh other risks. (Previous guidelines did not recommend aspirin in lower risk or healthy women.)
- The upper dosage of aspirin for high-risk women increases to 325 mg per day rather than 162 mg. This brings the women’s guidelines up to date with other recently published guidelines.

Consider reducing LDL cholesterol to less than 70 mg/dL in very high-risk women with heart disease (which may require a combination of cholesterol-lowering drugs).

This 2007 update provides the most current clinical recommendations for preventing CVD in women 20 and older and 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.

The authors note that these guidelines cover the primary and secondary prevention of chronic atherosclerotic vascular diseases. Recommendations for managing vascular disease before or after cardiac procedures or post-hospital and valvular heart disease are covered in other American Heart Association guidelines.

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American Academy of Family Physicians; American College of Obstetricians and Gynecologists; American College of Cardiology Foundation; Society of Thoracic Surgeons; American Medical Women's Association; Centers for Disease Control and Prevention, Ad Hoc Writing Group Member, Office of Research on Women's Health; Association of Black Cardiologists; World Heart Federation; National Heart, Lung, and Blood Institute; and American College of Nurse Practitioners; with representation from the American College of Physicians. (Representation does not imply endorsement by the American College of Physicians.)

In addition, this report has been endorsed by: American Academy of Physician Assistants; American Association for Clinical Chemistry; American Association of Cardiovascular and Pulmonary Rehabilitation; American College of Emergency Physicians; American Diabetes Association; American Geriatrics Society; American Society for Preventive Cardiology; American Society of Echocardiography; American Society of Nuclear Cardiology; Association of Women's Health, Obstetric and Neonatal Nurses; Global Alliance for Women's Health; The Mended Hearts, Inc; National Black Nurses Association; National Black Women's Health Imperative; National Women's Health Resource Center; North American Menopause Society; The Partnership for Gender-Specific Medicine at Columbia University; Preventive Cardiovascular Nurses Association; Society for Vascular Medicine and Biology; Society for Women's Health Research; Society of Geriatric Cardiology; Women in Thoracic Surgery; and WomenHeart: the National Coalition for Women with Heart Disease.

**Editors Note:** In 2004, the American Heart Association launched its multi-tiered cause marketing Go Red For Women movement to raise women's awareness of their risk for heart disease and to help them take action to reduce their risk. For more information on heart disease and stroke or the Go Red For Women movement, call **1-888-MY-HEART** or visit [goredforwomen.org](http://goredforwomen.org). The American Heart Association urges Congress to make the No. 1 killer of women a national priority by passing the HEART for Women Act this year. The HEART for Women Act is bipartisan federal legislation that would improve the prevention, diagnosis and treatment of cardiovascular disease in women. For more information, please visit [www.heartforwomen.org](http://www.heartforwomen.org).

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