Working together for womens cardiovascular health

Wednesday June 5 14.00 15.30 Clyde
Working together for womens cardiovascular health
Chair: Mr David Geldard and Ms Michaela Nuttall
BCS working party recommendations
Dr Jane Flint

Joint implementation with cardiac network patient and carer partnerships
Ms Beth Greenaway

Will a focus on women revolutionise integrated pathway development?
Mr John Albarran

Moving forward with rehab, prehab and prevention in women
Mrs Bernie Downey

Global perspective of progress
Prof Jennifer Mieres
Session Report

Summary
The session presented findings from the BCS Working Group for Womens Heart Health. Twelve Key Recommendations have been put forward to address cardiovascular disease in women. The presenters described a range of issues covering prevalence, awareness, treatment and rehabilitation for women with cardiovascular disease.

Introduction
Mr David Geldard and Ms Michaela Nuttall chaired the session. Mr Geldard opened the meeting by reminding the audience that more than half of all heart patients are women, but not enough come forward for treatment.

BCS Working Party Recommendations
Dr Jane Flint presented the twelve British Cardiovascular Society (BCS) Recommendations on womens heart health. Dr Flint BSc MD FRCP is a Consultant Cardiologist in Dudley, the Clinical Director of the Black Country Cardiac Network, the Chair of BCS Working Group Making Recommendations and a member of the BCS Council to Promote Women in the Cardiology Workforce. The Recommendations are for raising awareness, education, risk appreciation and prevention, fair referral, appropriate investigation, diversity impact assessment of care pathways, registry of data and gender-specific research into treatments, as well as proportionate inclusion of women in studies, multidisciplinary care in pregnancy, cardiac rehabilitation, psychosocial counselling, and diversity-conscious commissioning across Cardiac Networks. Dr Flint said that the Recommendations have made a major contribution to the European Heart Health Charter.
She told the audience that heart disease is the largest single cause of mortality in women, taking six times as many lives as breast cancer. However, womens perceptions do not correspond with the actual risk.

Joint implementation with cardiac network patient and carer partnerships
Ms Beth Greenaway told the audience that she is a 34-year-old Grown Up with Congenital Heart Disease (GUCH). She has had two open heart surgeries, one when she was aged 9, the other in 2005. She is vice-chair of the GUCH Patients Association and works as a personal fitness trainer. She explained that the mission of the GUCH Patients Association is to help adults who were born with a heart condition. It is a charity founded in 1993 by Professor Jane Somerville and now has about 4,000 members, of whom roughly half are women. It organises conferences and local groups and runs a freephone helpline, a quarterly newsletter, a website (including a message board) and information sheets.
Ms Greenaway described issues that concern GUCHs. According to some estimates, 80% of congenital heart patients are lost to follow-up or are not seen by GUCH specialists. Those patients have a poor ability to cope in medical settings, following their earlier experiences. They may have a limited understanding of their condition or its implications for the future, often arising from their childhood expectation that they would not have a proactive role in their treatment. They may have physical limitations that affect job choice and have a high unemployment rate. Many GUCH patients smoke (especially women), suffer from depression or anxiety, and many have difficulties with their relationships. She said that there are particular issues relating to pregnancy, pointing out that cardiac disease is a leading cause of maternal death in the UK (second only to suicide), and GUCH patients have a fear of passing on bad genes to their babies and are concerned about maternal life expectancy.
Ms Greenaway reminded the audience that she had mentioned her occupation as a personal fitness trainer to show that the majority of GUCHs are able to exercise, although some are afraid of it and certain medication can affect the ability to exercise. The GUCH Patients Association is organising and supporting events to encourage GUCHs to exercise.

Will a focus on women revolutionise integrated pathway development?

Mr John W Albarran encouraged a focus on womens heart health. Mr Albarran is a principal lecturer at the University of the West of England (Bristol) Faculty of Health and Social Care. He explained that care pathways are valuable in treating patients, but they have a tendency to refer to the ideal or average patient, so they often fail to address individual issues. He told the audience that, in the UK, one in six women dies of CHD and, in Europe, 10 women die of CHD every hour. In Europe, cardiovascular disease accounts of 43% of deaths in men, but 55% of deaths in women.

Mr Albarran described a study in Ireland that showed that women were more likely than men to delay seeking help following the onset of coronary problems. The main reasons are that they do not recognise the symptoms or believe that heart disease affects men predominantly. Those reasons apply particularly to women from ethnic minorities. The study also found that when women do present for treatment, there is a greater tendency for them to have atypical symptoms.

Mr Albarran outlined particular issues on the health profile of women with heart disease. He said that, on average, women are 10 to 20 years older than men are when they develop acute coronary syndrome or myocardial infarction. Furthermore, the presence of co-morbid factors may mask the heart disease. There may be difficulties with diagnostic investigations and treatment. For example, ECGs are less reliable in women during acute presentation, the role of aspirin as first line management in women with myocardial infarction (MI) is under debate, cardiac rehabilitation programmes may not be deemed relevant to the needs of women, and they are less likely to attend such programmes. He concluded that there seems to be a need to focus on the needs of women with heart disease.

Moving forward with Rehabilitation in Women

Professor Patrick Doherty, Chair of Rehabilitation and Research, Faculty of Health and Life Sciences, York St John University, described cardiac rehabilitation in women. He said that the literature shows that rehabilitation is underutilised by patients. That applies particularly to women, who tend to be less fit than men are, following MI. A study of 147 patients in the north west of England concluded that physicians were less likely to refer patients for rehabilitation if they were female, old or had low levels of fitness.

Professor Doherty explained that research has shown that men have greater energy expenditure than women during rehabilitation. Many rehabilitation programmes use the same exercises for men and women. Consequently, they use a greater proportion of womens available energy resources than of mens. That results in a higher proportion of women dropping out, because they are working relatively harder.

Global perspective of progress

[David, could you please insert the name of the American guest speaker? Leonard]

The American Heart Association has found that cardiovascular disease (CVD) is the highest cause of death in both women and men. However, women perceive cancer, particularly breast cancer, as a greater risk than CVD. Furthermore, only about a quarter of heart disease research subjects are women. The risk factors are high cholesterol, smoking, diabetes and hypertension, but obesity prevalence is growing, making it a particularly concern. Increasing numbers of women have become obese in the United States, particularly in Alabama and other southern states, during the past decades, often leading to heart disease. A red dress campaign is raising awareness of heart disease in women and advice on its prevention.

Panel Discussion

All the above speakers, as a panel, agreed that more needs to be done to raise awareness of heart disease in women. They suggested that people who had been through the Expert Patient Programme might be able to speak to others about womens heart health; they felt that there was a need to empower patients to participate in the Programme and local health providers should be encouraged to do that. Patient advocacy can increase awareness of the needs of women in cardiology. Many women feel more comfortable attending a womens clinic than a general one.

The Panel suggested that others ways of increasing awareness might be for female characters in soap operas to have heart attacks and there should be more serious articles in womens magazines.

Conclusion

Mr Geldard concluded the session by thanking all the speakers for having addressed a range of important issues concerning womens heart health.

Leonard Levy,
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Department of Healthl