

Heart Disease Prevention in US Women

There Is More Work to Be Done

DESPITE DECLINING mortality over the last few decades, cardiovascular disease (CVD) remains the leading cause of morbidity and mortality for both men and women in the United States.¹ Unfortunately, a common misconception is that heart disease is a “man’s disease,” when in fact, more women than men died of CVD in 1996.² In this issue of the ARCHIVES, Mosca et al³ address a very important component of effective CVD prevention by examining knowledge and perception of heart disease risk among US women. This article provides an important evaluation of the effectiveness of our ongoing patient and community health education efforts in disseminating knowledge of CVD. Effective health education efforts are an important first step in prevention strategies to further reduce the CVD burden in US women.

See also page 506

According to their results, more women perceive cancer (particularly breast cancer), not CVD, to be a more significant health concern for women.³ Certainly cancer is a major health problem for women; however, approximately 1 of every 26 women can expect to die of breast cancer, while 1 of every 2 women can expect to die of CVD.³ Unfortunately, the disease-specific nature of most prevention messages overshadows the larger goal of improving global health and reducing overall morbidity and mortality. In the context of prevention, it is not helpful to have cancer and CVD portrayed as mutually distinct, since these and other chronic conditions share certain risk factors (eg, age, diet, alcohol, physical inactivity). Importantly, our public health goal is to work to assure that women can choose to remain free of both CVD and cancer. From a public health perspective, a more useful and prudent strategy is to promote global chronic disease prevention strategies that encourage adoption of healthy lifestyles, including smoking cessation, increased physical activity, maintenance of desirable weight, and healthy eating habits.

The results reported by Mosca and colleagues raise important issues relevant to effective overall chronic disease prevention efforts. Individual perceptions of the most important health problems facing women was a key element of the article. Most women interviewed in the Mosca study

felt that CVD was an important health problem for women. While women reported that they were at least moderately informed about the disease, no individual heart disease risk factor was identified by more than one third of respondents.³ Misconception of actual risk likely influences attentiveness to risk reduction or disease prevention messages and, consequently, knowledge and behavior. More effective methods of disseminating information to women about their actual risk of disease are needed. Respondents in this study cited magazines as a commonly used source of health information. Given that these data document the need for a better understanding of CVD risk factors by US women, enhanced and more novel approaches that incorporate popular media should be explored.

A second important issue relates to our current presentation of messages and strategies for CVD prevention. The variation in responses by age and racial/ethnic group is noteworthy and provides support for the contention that many health promotion/disease prevention messages miss significant segments of our population. It is no coincidence that the larger percentage of “don’t know” responses occurred among African Americans, Hispanics, and older adults. In addition, women in these groups were less likely to correctly answer specific questions about CVD risk and prevention. Although there are differences in socioeconomic status across age and racial/ethnic groups, observed differences in knowledge and perception are most likely related to the sociocultural appropriateness of the message. Just as it is unwise to ignore the considerable heterogeneity that exists within the female population in the United States, it would equally unwise to assume homogeneity within groups defined by age or race/ethnicity. Thus, prevention efforts need to be tailored to adequately communicate our message to all Americans.

Health care providers are an important, but often overlooked, target population for CVD prevention messages and strategies focused on women. Most women feel comfortable talking with their physician about preventive health options; however, relatively few discuss heart disease with their physicians.³ In an era of increased time pressures on the patient-physician interaction caused by the increased penetrance of managed care, existing and creative strategies need to be focused on enhancing provider-patient communication for CVD prevention.⁴

Unfortunately, the important “take home messages” of this timely article are not comforting. A great deal of misinformation or lack of information exists in women’s perceptions of CVD risk and preventive strategies. An even larger gap exists for older women and some minority groups. At times, we could be tempted to step back and admire our previous success in reducing the burden from CVD mortality in the United States by more than 50% from the 1960s to the 1990s.⁵ However, data such as these remind us that much remains to be done in the area of CVD prevention among women in the United States.

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Clinical Pearl

Hyponatremia in Marathon Runners

The authors report on 7 individuals who developed serious hyponatremia during marathons, leading to one death. Five were women. Four additional women were identified after the paper was submitted. In marathon runners who develop nausea, vomiting, headache, seizures, or coma, the authors recommend considering the possibility of hyponatremia. (*Ann Intern Med*. 2000;132:711-714).