Issue 2

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The Foundation for Women's Wellness

Newsletter

Dear Friends,

In the January 20th issue of *Newsweek* magazine, I sympathetically nodded at the articulate observations of Dr. Michael Craig Miller, MD, editor-in-chief of the Harvard Mental Health Letter:

"*We may know what good health requires, but knowledge doesn't translate easily into action. Years or decades go by with lifestyle problems cruising below the radar. Once aware, we ponder change for a long while before implementing it.*" Then, maintaining healthful changes is often challenging.

I asked myself, how does an organization dedicated to improving women's health address this fundamental struggle of 'human nature versus healthy living'?

In this age of managed care, physicians have less time than ever to talk with you about the inherent complexities of medicine and how it applies to your unique profile. It is increasingly difficult to make sense of the mixed messages pervading the media. As women, our knowledge is further compromised because decades of medical research did not consider gender differences and excluded women as study subjects.

We at the Foundation for Women's Wellness are committed to being a sound source for women's health information. If the issues are complex, we will talk longer and write more. We will examine the substance and quality of the research behind the news and bring top medical experts to communicate with you. We will identify and raise funds for new research. By clarifying what we know and advancing science where we don't, we can help women live healthier lives.

"*Education is one of the best predictors of good health. Solid science leaves ample room for uncertainty and disagreement, but some experts are more expert than others," Dr. Miller continued. "The more you know, the easier it becomes to sort the useful advice from the flawed."*

We couldn't agree more.

Thank you for your continued support and warm reception to our first newsletter, educational gatherings and ongoing efforts. We cannot do it without you.

Yours in good health,

Sharon Helfant Cravitz, Executive Director

Heart Disease: #1 Cause of Death in Women

Causes, Symptoms, Risks, Prevention, & Treatment

The statistics are striking. Each year in the United States, more women will die of heart disease than from any other cause. Over the past two decades the heart disease death rate for men has dropped, while that for women has risen. One in two women will develop heart disease in her lifetime yet fewer than one in ten believes she is at risk, according to Dr. Nieca Goldberg cardiologist and chief of the Women's Heart Program at Lenox Hill Hospital in New York City. "Only 8% of American women realize [that heart disease] is a greater threat than cancer," reported *Time* magazine earlier this year.

Regardless of age, awareness of heart health and signs of heart problems are essential for reducing these escalating statistics. Most women develop signs of heart disease after age 50, but almost one-third of all women ages 45 to 54 already have cardiovascular disease and are unaware of it. Heart attack in younger women is not common, but when it occurs, it is more deadly.

> *"Fewer than one in ten women believes she is at risk for heart disease" despite the fact that "one of every two women will die of [the] disease."*
>
> *- Dr. Nieca Goldberg, M.D., "Women Are Not Small Men" (Ballantine Books, 2002)*

Women are less likely than men to be properly diagnosed, to be treated quickly, and to receive cardiac rehabilitation and counseling after a heart attack or stroke. It is only in the past ten years that medical research has uncovered critically important gender differences in our cardiovascular systems and in the causes, responses, and treatments for heart disease. It is essential that women of all ages be aware of these differences. "The vast majority of heart attacks in women could be prevented with a combination of lifestyle modifications and medication," states Dr. JoAnn Manson of Bringham and Women's Hospital. It is also important to be an aggressive self-advocate to ensure prompt and appropriate medical care if you are at high risk or are experiencing symptoms.

CAUSES & SYMPTOMS

In 90% of men, atherosclerosis or clogged arteries causes heart disease. However, one study found that only 32% of women complaining of chest pain showed signs of clogged arteries. Heart attack in women more often may be caused by artery spasms or by a narrowing or squeezing shut of arteries. This seems to happen in women with both "normal" looking arteries as well as clogged ones.

Women may have more abnormalities in their microvessels, or small arteries, that don't generally appear on angiograms, the standard test used to detect arterial plaque. It may also be that plaque behaves differently in women, both where it accumulates and how it causes heart attacks. Plaque often spreads more evenly over a woman's artery system and may erode the blood vessels rather than cause a rupture. Plaque erosion is seen most often in women who have smoked.

Classic heart attack symptoms include chest pain or a squeezing sensation, arm

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Women's Health FACTOIDS: *DID YOU KNOW?*

Osteoporosis Under Diagnosed in Too Many Women.

According to a recent survey in the *American Journal of Public Health,* up to one-third of post-menopausal women have osteoporosis, but only 2% are diagnosed and treated. Osteoporosis risk factors include:

- Menopause (natural or surgically induced).
- Increasing age.
- Being white or Asian and/or small-framed (127 lbs or less).
- Having a family history of osteoporosis or hip fracture.
- Having already had a fracture not related to major trauma.
- Being sedentary.
- Smoking.
- Heavy drinking.
- A poor diet, particularly one low in calcium.
- Taking corticosteroids, certain anticonvulsants, or excess doses of thyroid hormones for long periods.

Stress Consistently Higher in Women than Men.

In similar circumstances and at similar stages of life, women consistently report feeling more stress than do men. Unlike men, women's stress hormones and blood pressure tend to remain elevated at the end of the work day. Although stress is never listed as a cause of mortality, it's linked to many illnesses including deadly ones like heart disease (the number one cause of death in women). Finding ways to reduce stress is a serious health consideration for women. (See related article from FWW's Newsletter, v. 1, *"Friendship Critical for Reducing Stress in Women"*).

Irritable Bowel Syndrome: A Significant Women's Health Issue.

About two-thirds of Irritable Bowel Syndrome (IBS) sufferers are women. It is unclear whether or not this gender disparity is physical or due to women seeking medical care more often than male sufferers. IBS is an intestinal disorder that usually affects people ages 20 to 40. Its symptoms include abdominal discomfort or pain, bloating, and abnormal bowel function (constipation, diarrhea, or alternating between the two). IBS can also lead to low-grade depression and fatigue. On average it takes up to three years before IBS is correctly diagnosed because its symptoms are similar to other GI problems. There is currently no cure, but symptoms can be managed through medication and lifestyle changes.

Pre-Menstruation Can Make Some Health Conditions Worse.

Asthma, arthritis, epilepsy, migraine, diabetes and depression can all worsen just before menstruation. Most of these changes can be mitigated by a simple adjustment in medication. Be sure to talk to your health care provider if you experience such a pattern.

Timing of When You Take Medicine Important in its Effectiveness

A growing body of research suggests that the time of day you take medicine can make a difference in how you feel. For example, in most people blood pressure is highest in the morning but if medicine is taken at night, it has worn off by the time you need it most. Medicine that is designed to be most effective in the morning may be more effective for this situation. Consult your physician about medication timing if symptoms worsen at specific times of the day.

The Benefit of Self-Breast Exams.

It might not be fool proof *(what is?)*, but according to the *John Hopkins Medical Letter*, "More than half of all breast cancers are detected by women who notice changes and bring them to the attention of their doctors."

Most Women Tolerate Alcohol Less Well Than Men.

Women have one-fifth as much of the enzyme that breaks down alcohol in their stomachs than men. If alcohol bypasses the stomach and instead goes directly into the bloodstream, men and women tolerate the same amount.

Brain Development: Sex Differences Exist from Conception to Old Age.

Gender differences in the brain's development begin in the first trimester of pregnancy and continue throughout our lives. In utero, the brain becomes male when testosterone stimulates the intracellular growth of estrogen. In the female fetus, lower levels of estrogen are needed to develop the brain. At birth, boys have larger brains than girls; however, boys also have a greater risk of developmental disorders related to the brain. Such disorders include mental retardation, attention deficit disorder, hyperactivity, language impairments, stuttering and autism. Sex-specific differences in brain development continue through puberty and are maintained by hormones until old age when the differences become less apparent.

Heart Disease's Gender Disparities Found to be Significant

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pain, new or unusual shortness of breath, sweating, or fainting. However it is common for women to experience what doctor's still refer to as "atypical symptoms" *(see box on top of this page).*

Men also experience "atypical symptoms" 40% of the time, but women experience them more often and are less aware that these sensations signal a heart attack. This in part is why female patients are misdiagnosed more often than males.

RISK FACTORS

Risk factors may be inherited or a product of lifestyle habits. It is important to be aware of your personal risk and to address high-risk issues even if you have no obvious signs of heart disease. Practicing prevention and getting early treatment are the keys to long-term health.

Risk factors for women of all ages include:

- **Family history.** Immediate relatives such as parents or siblings who have had a heart attack, particularly when the heart attack has occurred prior to age 50, is an important risk indication.
- **Smoking and regular exposure to second-hand smoke.** Women who smoke are *more than three times* as likely as nonsmokers to have a heart attack. Smoking remains the number one risk factor for both sexes, but the risk is greater for women. For a woman smoker on oral contraception, a heart attack is 40% more likely than for a nonsmoker.
- **Excessive body weight**. Obesity is more prevalent in women than men. Being overweight or obese (a body mass index of 25 or greater) significantly stresses your heart and cardiovascular system. This constant stress increases chances of developing diabetes, high blood pressure, high cholesterol and high triglyceride levels.
- **Physical inactivity**. Being physically active reduces your chances of developing diabetes and obesity, two other risk factors for heart disease. It also helps to reduce stress and depression and can encourage healthy habits directly related to your heart's health such as healthy eating and smoking cessation.
- **Chronic high stress.** "It is estimated that 75% of all medical complaints [among men and women] are stress-related", according to Dr. Richard Helfant cardiologist and author of "*Women Take Heart*". Chronic, negative stress can cause atherosclerosis, high blood pressure, artery spasm, blood clotting and heart rhythm disturbances. Feeling a lack of control about the issues causing stress can compound its effects by leading to smoking, physical inactivity, poor eating habits, and social isolation.
- **Depression and social isolation.** Feelings of depression and/or social isolation can lead to increased risk of heart disease by possibly increasing blood pressure, physical inactivity, body weight, stress and propensity to smoke. Studies have also linked depression to a weakened immune system and increased platelet activity which, in turn, may lead to blood clots. Especially for women, having supportive relationships and social contact with family or friends is critical to maintaining good health *(see related article about stress and women in FWW newsletter v.1)*.
- **Cholesterol levels**. High total cholesterol levels increase the risk of heart disease by causing atherosclerosis. High LDL (bad) cholesterol increases plaque development on artery walls, while high HDL (good) cholesterol helps protect your heart by helping to remove and prevent the build up of plaque. Before menopause estrogen helps keep HDL levels high. It is important to regularly measure the whole lipid profile at all ages, but especially during menopause when estrogen levels decline. Current recommendations for overall cholesterol are no more than 200mg/dL with an LDL level of 100mg/dL or less.
- **Triglyceride levels.** Like cholesterol, triglycerides are natural and necessary blood fat lipids, but high levels are unhealthy for your heart. New studies suggest that high triglyceride levels are a greater threat to women than men. Maintaining a triglyceride level of less than 200 mg/dL is ideal.
- **High blood pressure or hypertension**. Hypertension is a main ingredient in heart disease and affects more than half of all women over the age of 45. By forcing the heart to work harder, irregular heartbeats can occur. If left untreated, the heart muscle weakens. High blood pressure can lead to atherosclerosis, circulation problems, heart failure, heart attack, stroke or kidney disease. A healthy level is 120/80.
- **Blood sugar levels and diabetes.** In diabetes, blood sugar cannot be properly metabolized. This is a major risk factor for heart disease. It is more common in women than men, particularly in women over age 45 and in women of color. Women with diabetes who have a heart attack are more likely to die than diabetic men or nondiabetic women. Testing blood sugar levels is an important tool in diagnosing diabetes and borderline diabetes.

Common Symptoms of Heart Attack in Women

- Fatigue
- Dizziness
- Nausea
- Shoulder pain or pressure *(or between the shoulder blades)*
- Neck pain or soreness
- Jaw pain or soreness
- Back pain
- Upper abdominal pressure or discomfort *(like severe indigestion)*

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Heart Health: Top Women's Health Concern

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- **Perimenopause or menopause.** During perimenopause and menopause, estrogen levels begin to decline causing changes in cholesterol, blood pressure, and body weight. It is important to control any such changes as early as possible and to have a thorough cardiac evaluation at this time.
- **Homocysteine levels.** Recent studies correlate high homocysteine levels with an increase in artery wall damage and arterial clogging. For women with a family history of heart disease prior to age 50 and without other risk factors, homocysteine levels should be checked. Common causes of high homocysteine are vitamin B deficiencies (folic acid, B6, B12), smoking, low estrogen, underactive thyroid, kidney failure, and stress.
- **Insulin resistance or metabolic syndrome.** This syndrome is a condition where the body becomes insensitive to insulin in breaking down sugar. It may lead to adult onset diabetes. According to Dr. Nieca Goldberg, metabolic syndrome is increasingly diagnosed in women and is characterized by waist size greater than 35 inches; BMI greater than or equal to 30; more an apple than a pear body shape; elevated triglycerides; HDL less than 50 mg/dL; blood pressure greater than or equal to 130/85; and blood sugar greater than or equal to 110 mg/dL.
- **C-Reactive protein (CRP) and fibrinogen levels**. Both of these substances are indicators of arterial inflammation. Recent research has found that a high level of CRP is a greater heart attack risk factor than low LDL (bad) cholesterol for women. This is significant because half of all heart attacks occur in people with normal cholesterol levels. High fibrinogen levels are generally seen in women and men who smoke and/or have a family history of heart disease at a young age.
- **Lp(a) levels.** Lp(a) levels higher than 30mg/dL have recently been found to increase heart disease risk in women. Lp(a) levels increase at menopause in the absence of hormone replacement therapy. They are not usually checked unless there is an absence of other risk factors.
- **Race.** Women of color have a significantly greater risk than white women of developing many risk factors associated with heart attack and stroke.

If you are under the age of 50, risk factors also include:

- **Hysterectomy or surgically induced menopause.** These procedures reduce estrogen production making other risk factors more significant. *(See "perimenopause/menopause" above).*
- **Polycystic ovary syndrome (POS).** POS is a hormone disorder characterized by irregular periods and high levels of testosterone and insulin. POS increases the risk of heart attack by increasing the likelihood of insulin resistance, high blood sugar, low HDL / high LDL cholesterol, high triglycerides, and high blood pressure.

PREVENTION & TREATMENT

There is much you can do to prevent, treat, and reverse heart disease. First know your risk factors: learn how to address them: and take action. Many risk factors can be improved by lifestyle changes. These include attention to diet, exercise, reducing stress and maintaining a healthy weight. Studies find that even moderate changes can be extremely beneficial. One study reported in *The New York Times* found that overweight patients who lost only 7% of their total body weight reduced their diabetes risk by 58%. For smokers, the risk of heart attack is cut in half within two years of quitting smoking and reduced to zero within 10 years.

In some cases medication for the short or long-term and/or surgery are also essential in treating cardiovascular disease. Please consult with your physician or a cardiologist about these options.

We also recommended that you re-test certain factors such as cholesterol and homocysteine levels a second time if initial testing is high and you are not suffering from symptoms and do not have any other risk factors. Be aware that certain tests, like a cardiac stress test, can result in false negatives about one-third of the time, and are less reliable in women than men. Other tests that are generally more reliable may be a better measure of possible heart disease (such as a nuclear scan or echocardiography).

Make sure to tell all physicians you see about any other medications, both prescribed and over-the-counter, that you are currently taking since drug interactions can be dangerous.

Women can greatly reduce their chances of developing heart disease by being aware of these gender differences. Knowing your own personal health profile, taking action, and being an aggressive self-advocate when receiving treatment are key to mitigating this most prevalent women's health issue.

Sources: "*Women are Not Small Men: Life-Saving Strategies for Preventing and Healing Heart Disease in Women*" by Nieca Goldberg, M.D. (Ballantine Books, 2002). *"Women Take Heart: A Leading Cardiologist's Breakthrough Program to Help Women Combat Heart Disease"* by Richard H. Helfant, M.D. (G.P. Putnam's Sons, 1993). *"The No.1 Killer of Women"* by Christine Gorman, *Time* Magazine, April 28, 2003. *"Searching for Answers in the Great Inflammation Debate"*, *Cardiology*, American College of Cardiology, March, 2003. *"Investigating Source of Women's Heart Disease"* by Jane E. Allen, *Los Angeles Times*, April 2, 2001.

Hormone Therapy & the Latest Reports from the Women's Health Initiative:

A Conversation with Lila Nachtigall, MD

Last year, the National Institutes of Health halted one trial of its multi-trial women's health study known as the Women's Health Initiative (WHI). This particular piece ceased five years into its eight year investigation because it was determined that certain health risks outweighed benefits. This trial was testing an estrogen/progestin combination pill treatment known as Prempro.™

Lila Nachtigall, MD, founder and president of the Foundation for Women's Wellness, is a professor of obstetrics and gynecology at the New York University School of Medicine. She is internationally recognized as a leader in the field of menopause and hormone therapy (HT).

Q: What are your overall comments about the Women's Health Initiative (WHI) and its findings?

A: Overall, the WHI is a very good, well-designed study. It included 16,000 women, who were well matched, and placebo-controlled. As in any study, however, there were also problems. It included much older women than we usually start on hormone therapy (HT), with 21% of participants over age 70 and 66% over age 60 and they were having no menopausal symptoms. This is not the population that we usually start on estrogen or estrogen/progestin combinations. Most women begin on HT in their fifties and go on it for hot flushes. Very rarely do we *start* someone in their sixties or older and, if we do, we usually prescribe a much lower dose than what was used in this study. The women studied were given one drug (Prempro™), which contains a full dose of estrogen and a full, daily dose of progestin. So, this is an older population, starting on a full dose of HT, including daily, oral progestin. In addition, the average weight of these women was much higher than the normal weight range recommended for this age group.

The second group being studied is women who have had hysterectomies and were given estrogen alone (Premarin™). As far as we know there have been no adverse results for these women, and this portion of the study is ongoing.

The results of WHI are most applicable for women starting on Prempro™ at age 63. It is not necessarily accurate to apply *all* of the WHI findings to *all* women on *all* forms of HT. In determining your own individual risk many factors should be assessed before starting HT, and these factors should be periodically reassessed. HT has become a politically charged issue – either you're for it or against it but you should be only for the patient.

Treatment must be individualized. Some women should not be on HT. Others may do best with patches, others pills, some with progestin cyclically, some with progestin every day. HT has been around for over 60 years and has been studied far more than any other treatment option we have today for dealing with menopausal symptoms. The WHI findings are very helpful and important, but they should be considered in the context of all the information we have about HT, remembering that all medicinal treatments require a risk vs. benefit assessment on an individual basis, with periodic re-evaluation.

Q: What can women conclude from the WHI results?

A: Many experts, including the National Institutes of Health (NIH), now suggest using the lowest dose of estrogen that will achieve success. This is certainly good medical practice in general, and in HT specifically. It reminds many of us to re-evaluate patients to discern whether lowering the dose might be beneficial at this time. The Women's HOPE study (published in 2001) showed that lower doses are effective in treating hot flushes, bone density, and vaginal maturation when compared to a placebo. It is always important to assess why HT is being prescribed, however, the low dose options seem to be a promising alternative.

The WHI also clarified that estrogen should not be used for primary prevention of heart disease. There are better drug choices for treating high cholesterol such as statins. Women with blood clot disorders or blood vessel disease and women with unstable angina or who have had a heart attack should not be prescribed HT.

The issue of clotting is one that warrants further study in order to better understand potential risk in women on different forms of HT. Rob Flaumenhaft, MD, PhD of Harvard Medical School and FWW Scientific Review Board chair and I are launching a study to examine the incidence of clotting before and after women begin either the estrogen/progestin combination or estrogen alone, in patch or pill form. *(Findings will be published in a future FWW newsletter).*

The WHI showed significant positive results for preventing bone fractures. There were 44 fewer fractures per 10,000 in the hormone-treated group. When we look at fractures or osteoporosis prevention, HT is very effective. There are other also treatment options for this purpose such as Raloxiphene and bisphosphates, so just like all else, treatment should be individualized.

Q: What about recent media reports of an increase in breast cancer for women on HT?

A: The WHI found a less than one-tenth of one percent increase in breast cancer, or eight more cases per 100,000, among women in the study on HT. This result is not statistically significant, nominally or adjusted. These results should be weighed in balance. The actual increased risk of breast cancer for most women on HT is small.

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Hormone Therapy Research News: *Q & A with Lila Nachtigall, MD*

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Q: What are the individual factors you review with your patients in assessing the best treatment?

A: First, it is important to assess why you are currently taking, or considering taking, HT. Are you are suffering from menopausal symptoms such as hot flushes, night sweats, insomnia, rapid mood changes, and/or sexual dysfunction (lack of libido and/or vaginal dryness)? This latter issue is one that women unnecessarily suffer from for many years during and after menopause and are too embarrassed to discuss with their physician.

Are you at high risk of osteoporosis? Assessing your bone density, family history, and personal risk factors are important. There are also excellent alternatives for both prevention and treatment of osteoporosis, but none of them have been studied truly long-term.

Are you at high risk of heart disease? Heart disease and dementia prevention are not reasons to be on HT.

It is important to assess risk on an individual basis and to periodically reassess why, and at what dose, patients are taking HT, especially for those ages 65 or older. There are risks with any medicinal treatment, herbal alternatives included. It is important to remember that the majority of women on HT do fine.

We have learned that lower-dose HT may be a viable alternative to today's full-dose options. There are also different forms to consider in addition to dosage, such as patch, pill, or topical creams that treat vaginal atrophy.

Q: What about women in their fifties taking HT for menopausal symptoms?

A: A major injustice of the WHI is not allowing a statement about short-term use being safe for the majority of women. Recent studies suggest that the findings regarding heart disease in women on HT are not applicable to younger, healthy women who use HT to treat menopausal symptoms. The majority of HT users are women in their fifties who go on it because of debilitating menopausal symptoms such as hot flushes, insomnia, rapid mood changes, and vaginal atrophy. For most of these women, HT is a viable and effective treatment option, but each woman should be evaluated on an individual basis.

FOUNDATION FOR
WOMEN'S WELLNESS

1000 S. Race Street
Denver, CO 80209