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Gender matters: A review of unique aspects of cardiovascular health in women

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Cardiovascular Disease (CVD) continues to be the leading cause of death among women in Australia. There is stagnation in the improvements in incidence and mortality of coronary heart disease, specifically among younger women. Underdiagnosed presentations of CVD including Spontaneous Coronary Artery Dissection (SCAD), stress- induced cardiomyopathy and HfpEF are more prevalent in women. This review focuses on recent insights into diagnosis, treatment and prevention of CVD in women. Atherosclerotic CVD: Women are more likely than men to present without chest pain and have higher mortality than men, especially among younger age groups. Recent study of young patients diagnosed with Acute Myocardial Infarction (AMI) found AMI with non-obstructive coronary arteries (MINOCA) more prevalent in women. Etiology included coronary artery vasospasm, SCAD, or coronary artery embolization. Takotsubo Cardiomyopathy mainly affected postmenopausal women. Traditional risk factors are increasing in prevalence among women and several emerging risk factors are seen. Diabetes seems to have more adverse CAD effects in women including impaired endothelium-dependent vasodilation and a hyper-coagulable state. Heart Failure: Heart failure with preserved ejection fraction (HFpEF) is more prevalent in women. Pathophysiology of HFpEF is poorly understood and it disproportionately affects elderly women. It can be concluded that outcomes of CVD remain poorer in women. The cause for this is multifactorial. Women are underrepresented in CVD research, thereby there is lack of data to guide gender specific diagnostic and therapeutic interventions. Women are not receiving optimal treatment, which comes from lack of access and/or lack of knowledge. Women are less likely to receive guideline based preventive treatment compared to men of similar CVD risk. Women are less likely to attend cardiac rehabilitation compared to men. In summary women are underrepresented in clinical trials and are not receiving optimal treatment. Ongoing gender specific research is needed.

Biography

Dr Mukherjee has received her MBBS and commenced internship in Brisbane. Her Postgraduate Medical Training was in Melbourne. She was awarded her Fellowship of the Royal Australian College of Physicians in 2004. Receiving a postgraduate medical research scholarship from the Cardiac Society of Australia and New Zealand and National Health and Medical Research Council (NHMRC), she has completed her PhD (Monash University) at The Alfred Hospital. She has completed her Fellowship in Interventional Cardiology in 2009 at The Hull and East Yorkshire NHS trust, UK. She is currently Senior Lecturer in Monash University and has an active role in clinical teaching of medical graduates. She is a Fellow of RACP, Fellow of CSANZ and n member of Women in Innovation, SCAI, Washington. Her clinical and research interests include role of oxidative stress in clinical presentations of coronary artery disease, coronary intervention and age and gender based issues in interventional cardiology.

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