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American women and myocardial infarction: TUMS® or angiogram?

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The number 1 of death in America is Heart Disease (HD). One person dies every 6 seconds. In America, 2009 studies showed the average life expectancy of a man was 72.2 years. For American women, life expectancy that same year was 79.3 years. In contrast, the 2013 life expectancy of a man was 76.2 years (i.e., 4.6 years gain); for a woman, it was 81.3 years (i.e., 2.7 year gain). What happened to relatively shorten a woman's lifespan? First, why are men doing better at longevity? Men are: Smoking less, avoiding obesity, and being treated for MI, hypertension and hypercholesterolemia. Women are: more likely to die due to undiagnosed HD, less likely to seek care for HD, and take cardiac medications irregularly. The American Heart Association admits that heart disease is "often" undiagnosed and untreated in women, and that the risk factor awareness still needs improvement. Gina Lundberg, MD, national spokesperson for the American Heart Association, states "women seeking doctors for HD; and many doctors don't treat their symptoms as aggressively as they do in men. They'll say you have an upset stomach or send you home." Obesity, smoking, and alcohol are killing us. If a woman smokes and has an MI, she is likely to delay her care. She won't get the same treatment as a man; she is more likely to go into congestive heart failure, shock, and death. Other variables include the city of residence, ethnicity, and education (except for Latinas, the "Hispanic paradox").

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To screen or not to screen: That is the question

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Genetic screening has been an intense topic in virtually all areas of medicine, with existing controversial data on whether individuals should or should not be genetically screened for risk. Examining salt-sensitive hypertension as an example, several genetic targets have been identified to be associated with salt-sensitive hypertension. These target genes associated with salt-sensitive hypertension should provide insights into the pathophysiology of the disease and can act as targets for novel drug therapies. However, comparing these target genes with biomarkers, it is evident that target genes provide a weaker predictor of salt-sensitive hypertension. Although target genes are not affected by someone's age, sex, medications and diet and they never change in someone's lifetime, biomarkers of salt-sensitivity such as higher aldosterone and lower N-terminal proatrial natriuretic peptide are more relevant in predicting individuals at risk to salt-sensitive hypertension than target gene variants. As such, it is not advised to perform routine genetic testing until clear evidence exists on a better management as a result of such genetic testing. Until then, genetic screening will be reserved to screening individuals fulfilling certain criteria and with a family history of salt-sensitive hypertension within the context of clinical trials.

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