

THE ROLE OF THE OB/GYN AND THE SCREENING OF WOMEN'S HEART DISEASE

Worldwide, cardiovascular disease (CVD) is the largest single cause of death among women,¹ accounting for one-third of all deaths. As life expectancy continues to increase and economies become more industrialized, the burden of CVD in women in the global economy will continue to increase.² In the U.S. alone, \$403 billion was spent in 2006 on health care or on lost productivity from CVD, compared to \$190 billion for cancer and \$29 billion for HIV.³

According to the World Health Organization, reducing the death rate from chronic disease, including heart disease, stroke and diabetes, by just 2 percent over one decade would prevent 36 million deaths and save billions of dollars in associated costs.⁴

SCREENING CHALLENGES

Primary care physicians play a key role in impacting chronic disease in general and heart disease in particular. In the U.S., the increasingly important role played by OB/GYNs in primary care raises an interesting question. What impact can today's OB/GYN have in screening for heart disease and decreasing its associated morbidity and mortality?

Findings from literature relevant to this question are mixed. In an American Journal of Obstetrics & Gynecology article, members of the South Atlantic Association of Obstetricians and Gynecologists were surveyed to determine the type of primary care they offered and their attitudes about the training of residents in obstetrics and gynecology. Sixty percent of respondents stated that they screen patients for cholesterol. Robert V. Higgins, M.D., reported that less than 30 percent of OB/GYN physicians are screening in this age group.⁵

Inconsistencies also exist in professional recommendations for CVD screening. The American Heart Association (AHA) recommends cholesterol screening for all women by the age of 20. In 2003, American Congress of Obstetricians and Gynecologists (ACOG)

guidelines also recommended that screening commence at age 20.⁶ However, the most recent (2004) ACOG recommendations state that routine cholesterol screenings should start at age 40, unless the patient has other risk factors, and continue every five years thereafter. This obvious discrepancy in recommendations for cholesterol screening and concurrent lack of clear screening guidelines has caused confusion among physicians.

Compounding the cholesterol screening confusion that already exists within the physician community are misconceptions from patients about which conditions actually pose the greatest health risks. In 2003, an AHA survey of 1,000 women showed that only thirteen percent of patients identified heart disease and stroke as their greatest health concern. A monograph on the management of dyslipidemia published the same year revealed that only one out of three women correctly identified CVD as the leading cause of death in their gender.⁷

An extensive 1980-2003 survey conducted by the National Center for Heart Health Statistics found that OB/GYN physicians accounted for 31 percent of all visits of women in the 20-40 age group.⁸ With this significant percentage of women relying on their OB/GYN for primary care services, it becomes our great responsibility to explain their CVD risk, assist in proper screening and counsel on healthy lifestyle choices.



Steven Foley, M.D., Ob/Gyn
Advanced Gynecology
Colorado Springs,
Colo.

THE ROLE OF THE LIPID PROFILE

One of the simplest solutions to identifying risk is through a lipid profile. In the past, the need for fasting prior to obtaining a lipid profile was a considerable road block to testing when the patient presented for their annual gynecological exam or any other exam. Fortunately, a non-fasting cholesterol screening called the VAP® (Vertical Auto Profile) Cholesterol Test is now available to clinicians. The test is performed with a simple blood draw, making it easy to combine with last-minute or regular patient visits such as an annual checkup. This has led to what is now a common protocol in my practice: getting a “VAP with a Pap.”

Unlike the standard cholesterol test, for which LDL is calculated from other values, the VAP Test reports directly measured LDL, obviating the need for fasting. This direct method allows for a much more accurate reporting of the patient’s lipid status. The VAP Test can be conveniently ordered when the patient is in the office and allows us, as physicians, the opportunity to screen for heart disease on the spot.

The VAP advanced lipid profile also measures other values that the standard lipid panel does not, including VLDL (very low density lipoprotein), Lp(a), HDL subtypes (HDL₂ and HDL₃) and IDL (intermediate-density lipoprotein). HDL₂, for example, can be disproportionately lower in patients with insulin resistance and has been used effectively compared to HDL alone. This subtype has been of particular value when examining patients with potential Polycystic Ovarian Syndrome (PCOS). I use the VAP Test to look at HDL₂ along with triglycerides and also the pattern size of the LDL in order to assess women for insulin resistance, and therefore, the possibility of PCOS.

Based on my own experience and on respected survey results, women show the need and desire for guidance when it comes to these issues. In the previously referenced AHA survey, almost all women surveyed said they would like to discuss heart disease risk with their physicians. However, only 41 percent of women stated they had ever done so.⁹

Clearly, a high percentage of women see their OB/GYN regularly, especially during their reproductive years. Women at this age need to be screened for CVD risk to ensure a healthier future. By proactively screening for disease and offering treatment and lifestyle changes, we can help our patients save money and lead much healthier lives. However, to achieve this goal, the OB/GYN must play a greater role in our patients’ heart health.

Many women exercise, are healthy and even engage in marathons, but their genetics think differently. Sadly, this is a story that’s repeated on a daily basis across our nation, and increasingly it’s CVD in women that is overlooked, under diagnosed and under treated.

I recently saw a 24-year-old patient in my office with a BMI of 23. She was a shoe company executive and ran at least 10 miles per day, yet displayed markedly abnormal lipids. Had I not screened her for this abnormality, she would most likely have succumbed to CVD in the future before having the opportunity to make critical lifestyle changes that would prevent an event.

Statistics show that the first sign of cardiac disease in more than half of all patients is sudden death. The time to test and treat is certainly before patients have a myocardial infarction or stroke.

CONCLUSION

We all recommend our patients get a mammogram and then allow another physician to follow up with the results. The VAP Cholesterol Test is similar in that we can obtain the test and then refer the patient to the appropriate source. As primary care doctors, however, we also retain the option to treat these patients. It’s a course worth considering, since many female patients feel more comfortable in our office and seem to respond very well when their OB/GYN cares for more than just their cervix.

Based on my experience, the clinical evidence and prudent guidelines, I recommend that all patients over the age of 20 be screened for CVD risk. Certainly, getting a VAP Test at the time of the patient’s Pap smear is a very appropriate — and most likely convenient — time for our patients.

References

- ¹ Women. *World Heart Federation website*. October 6, 2006.
- ² Yusuf, et al Global Burden of Cardiovascular Disease: Part 2: General Considerations, The Epidemiological Transition, Risk Factors, and Impact of Urbanization, *Circ*. 2001; 104:2746-2753.
- ³ Thon et al American Heart Association statistics committee, *Circ*. 2005;111:499-510.
- ⁴ Strong. et al Preventing Chronic Disease: How many lives can we save? *Lancet*. 2005; 366:1578-1582.
- ⁵ Higgins. Primary Care by Obstetricians & Gynecologists: Attitudes of Members of the South Atlantic Association of OB/GYN; *American Journal of Obstetrics & Gynecology*. 1997: 117:311 – 318.
- ⁶ Clinical Updates in Women’s Healthcare. Chest Pain and Heart Disease. *Redberg, Mora, Barbour*. January 2007, ACOG.
- ⁷ *Circulation*. 2004;109:573-579 (Page: 575).
- ⁸ The National Center for Heart Health Statistics. Health United States 2005: With chart book on Trends in the Health of Americans. Hyattsville, Maryland:WCHS. 2005.
- ⁹ *Circulation*. 2004;109:573-579 (Page: 578).