
Roundtable: Suspected CHD Risk

The proper assessment of risk factors for cardiovascular disease (CVD) and coronary heart disease (CHD) and their accurate diagnosis are essential for today's practitioners. Menopause Management asked four diverse providers to talk to us about their assessment approaches, their patient-counseling methods, and their treatment protocols. The result is a rare and lively exchange of practical management approaches.

Participants

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What is your initial approach to identifying risk factors for CHD in perimenopausal women?

Havens: I created a form for this purpose. I start by going through family history (e.g., death of a parent before age 60), smoking, diet, exercise history, and weight. I also get into factors such as unexpressed anger and depression, partly because there has been some interesting literature on that. I do diabetes and pre-diabetes screening, looking for insulin resistance, because if I can pick it up 5 years before they actually develop diabetes, it will help in the long run. I look for premature menopause, a history of induced menopause before age 45, high blood pressure, and lifestyle risk factors, such as stress.

Kaunitz: I focus on basics. I don't use standardized questions, because I think one's approach varies depending on whether a woman has a relationship with a primary care physician (PCP). For example, she might need additional testing if she has not been seeing a PCP.

When a woman comes in, we record her weight and blood pressure and determine which medications she is taking. This gives us clues to her overall health, including the areas she and I need to prioritize.

Gorodeski: In a general gynecology practice with special emphasis on GYN-endocrine-related disorders and menopause, I see a trend toward an increasing number of referred/self-referred perimenopausal and postmenopausal women who choose their gynecologist as their PCP.

Less frequently, I also see older postmenopausal women, 65 years of age and above, with established chronic disease (e.g., hypertension, diabetes, CHD, lipidemia) who come in for a "well-woman visit" (ICD-9 code v72.3), for the evaluation of menopausal symptoms (ICD-9 code 627.2), or are referred by their PCP for issues related to late climacteric symptoms, such as atrophic vaginitis and/or osteopenia/osteoporosis. In this mixed group, some will have previously identified CVD risk factors, such as family or self-history of CVD or related conditions prior to their exam.

The patient fills out a questionnaire outlining pertinent historical and present medical information with the assistance of a physician assistant (PA). The recently published ACOG questionnaire is detailed and practical, and it can be simplified according to the needs and specifications of the physician.

The PA also obtains measurements of blood pressure, urine glucose, and weight and height (to assess overweight/obesity

and type of obesity [gluteal vs central]), providing a screening basis for CVD.

Choi: For all women, family history, weight-height ratio, blood pressure, and general health behavior—such as smoking, physical activity, nutritional intake, and stress management—are assessed as an integral part of the periodic gynecologic exam.

Which tests do you undertake?

Havens: If patients are obese, hypertensive, and have elevated lipids, I will do a 2-hour postprandial glucose test. I also check C-reactive proteins and thyroid-stimulating hormone (TSH).

Kaunitz: ACOG has supported the position that in perimenopausal women, a baseline fasting lipid screen, including triglycerides and lipoprotein subfractions, is more important than total cholesterol. I think we need to be careful in interpreting the lipid results, however. There is often a lot of confusion about the cutoffs. I'm an Ob/Gyn and I will, if necessary, refer the patient to an internist for lipid-lowering therapy. My role would be identifying the problem, explaining it to the patient, and advising her on which direction she needs to go.

I'd also like to emphasize that we shouldn't underestimate the role we can play in identifying hypertension in our patients. Just in the last year I've had a number of women I've been following for years who have developed hypertension in their 50s, despite taking good care of themselves. Many of them have a family history of hypertension, but they are often in denial or have the feeling that they've done something wrong (e.g., "I don't smoke, I keep my weight healthy, and I exercise. How could I have developed high blood pressure?"). That's when you have to sit them down and talk about their family history and the importance of identifying hypertension early.

We should also include fasting blood

sugar and TSH tests as part of the initial screen for women in their 40s and 50s.

Gorodeski: In perimenopausal and postmenopausal women who are asymptomatic for CVD, a plasma lipid profile (total cholesterol, HDL, LDL, total triglycerides) and postprandial urine or plasma glucose are considered essential, unless it is documented that these have been assessed by another physician within the last 6 to 12 months. Annual hemoglobin A_{1c} (HbA_{1c}) testing is recommended for women with a family history of diabetes. Symptomatic perimenopausal and postmenopausal women are referred to an internist, endocrinologist, or cardiologist, depending on their insurance plan.

Choi: In general, I advise standard laboratory tests for perimenopausal women, including a complete blood count, fasting glucose level, lipid profile, and TSH.

Once you identify postmenopausal women with risk factors, what type of counseling do you offer them?

Havens: There is good evidence to support the reduction in risk of heart attacks with behavioral intervention. Usually the first thing I try to focus on is quitting smoking if they smoke. I have a smoking cessation program that I will get people into, and we can offer them options such as the nicotine patch or Zyban (bupropion HCl), depending on what works best for their lifestyle.

If lipids are elevated, I talk to them about reducing serum cholesterol and about the importance of exercise. I also talk to them about weight if that is an issue. I will mention to them the benefits of one alcoholic drink per day on the heart, but I also will tell them about the increased breast cancer risk with alcohol use, which is the trade-off. If blood pressure is high, we discuss treatment options.

I also work with a wonderful behav-

ioral psychologist, and I will do the initial talk with patients about the importance of the mind-body connection and then refer them to her if they're interested in learning more about stress-reduction techniques. Another thing I sometimes do when talking about stress reduction is refer patients to a great book called *Self-Nurture: Learning to Care for Yourself as Effectively as You Care for Everyone Else*, by Alice D. Domar, PhD, and Henry Dreher. I think giving this type of information to patients who want it helps bring prevention down to a realistic level in terms of everyday things they can do to take care of themselves.

Kaunitz: Weight management is always a big issue and an important one to discuss in the context of cardiovascular risk factors. In the aftermath of the Women's Health Initiative, one of the things I most frequently find myself counseling women about these days, though, is hormone therapy (HT) and our confidence that it does *not* offer cardioprotection. I think clinicians have to realize that this is something that is on a lot of women's minds, and they have to make the time to have an extended dialogue if that's what the woman needs. I see it as an opportunity to reassess her needs and talk about not only HT and CVD, but also osteoporosis and other issues related to menopause.

Gorodeski: It would depend on the type of risk factor. For instance, normotensive, normoglycemic women with a family history of CVD are encouraged to make lifestyle modifications and follow up with continued screening. Hypercholesterolemic women are counseled about the use of statins. Asymptomatic, mildly hypertensive, or diabetic women are encouraged to try a trial of diet and weight reduction for a defined duration (e.g., 3 to 6 months).

Choi: As a nurse practitioner, I emphasize health promotion and health

counseling. General health behavior is addressed comfortably in the course of gathering information and performing the physical assessment. Women who smoke are advised of the deleterious effects on multiple body systems and urged to develop a smoking-cessation plan or undertake an interventional program. Women who have borderline hypertension are encouraged to change behaviors that may modify their blood pressure. Women who are overweight or obese are encouraged to consider workable ideas for change. Many women are unaware of the high sodium and fat content in processed foods and are willing to make needed changes when they have a better understanding of the factors that impact blood pressure and weight.

Women need assistance in identifying practical solutions for eating excessively or unwisely. The need for weight management is a common theme and concern in women's health care. Appropriate food intake and the need for adequate physical activity are explored. Busy women need practical recommendations for including exercise in their daily agenda. I emphasize that exercise or physical activity must become a priority or it won't be done. Good intentions are helpful but not adequate. Finding an activity that women will find enjoyable is essential. Simply recording food intake and the circumstances surrounding it can bring into consciousness the triggers of excessive or unhealthful eating behavior. In a supportive dialogue, stressful life events can be identified and acknowledged, and assistance can be sought when needed. Clinicians can be important conduits to professional and community resources.

In women with abnormal lipid profiles, which drugs would you consider?

Havens: I think statins are a good choice, and they have certainly been shown to work well. If a woman chooses HT, I encourage her to use natural micronized

progesterone, such as Prometrium. The Postmenopausal Estrogen/Progestin Interventions (PEPI) trial showed better lipid profiles with Prometrium.

It's important to counsel women about diet and exercise, but there are women who are convinced that they won't work. I try to encourage these women as much as possible, but if they come in with high cholesterol I usually will start them on medication.

I usually wait about 3 months after starting or changing a medication to recheck lipids. I also check liver function at 6 weeks, 12 weeks, and then every 6 months for the first year and yearly after that.

Kaunitz: As an Ob/Gyn, I would refer the patient with hypertension or lipid disorders to her PCP and then try to work closely with that physician to make sure there is an exchange of information back and forth, since I don't manage lipid disorders or hypertension myself. When a PCP refers a patient to me, I make sure that physician gets a note from me from the first visit and all subsequent visits, and I let the patient know this. It's very meaningful to some of them, because it gets to the heart of what we all ideally want, which is coordinated, continuing health care. It also improves compliance, because those patients know their PCP is going to hear that they have elevated blood sugar or that I'm concerned about their weight or their smoking. This sharing of information between providers is important but, unfortunately, I don't see it happening often enough. It's easy enough to do and we should all be doing it.

Gorodeski: Depending on the degree and type of lipidemia, I counsel asymptomatic perimenopausal and postmenopausal women about lifestyle modifications, including stress reduction, diet, and exercise. If no significant improvement is seen within a defined period of time—both in general health and in lipid profile—I advise these women about statins.

I do not use HT as a primary or secondary modality to manage hyperlipidemia. Patients on HT/ET are brought up to date regarding new developments in the field, and if they choose to continue their HT/ET, I adjust the hormone treatment to obtain a less risky outcome and a more favorable effect regarding plasma lipids. In addition to general monitoring of HT/ET, I also advise hyperlipidemic patients about the need for semiannual lipid profiles until satisfactory levels (according to AHA guidelines) are reached, followed by annual testing.

Choi: With borderline elevations in cholesterol levels, I counsel women on necessary dietary changes and reevaluate lipid components in a year to assess the effectiveness of their behavioral actions. With moderate or severe lipid abnormalities, I recommend further evaluation by the women's internist or family practice clinician.

In patients with mild to moderate hypertension, what is your treatment approach? Do you conduct follow-up yourself, or do you think they need to be followed by a hypertension specialist?

Havens: I think it's important to talk a little bit about stress when you're dealing with hypertension, because we need to recognize the effect that higher cortisol levels have on the body. If patients are prediabetic or diabetic I usually start by initiating an angiotensin-converting enzyme (ACE) inhibitor, or I start them on hydrochlorothiazide and then add the ACE inhibitor. If they are not diabetic I will try an ACE inhibitor or a beta-blocker. Sometimes I *do* use a beta-blocker in a diabetic or prediabetic patient, but I will use Coreg (carvedilol), because it is associated with the least amount of insulin resistance. I do most of the follow-up myself unless the patient's hypertension is very hard to control.

Kaunitz: This is another instance where I will start the dialogue and expect that patients will go to their PCP for treatment. If they don't have a PCP, then we talk about that, and I can refer them to someone with whom I have a relationship. You often hear all kinds of excuses about why they don't have a PCP or think they don't need one. I see my role as an indirect one, in that I screen and I coordinate, and then I keep the ball rolling to make sure they follow up with a PCP and get the appropriate treatment. I'm a communicator, and some of my patients might feel that I nag them too much, but I want to act as a bridge for them and keep them going in the right direction.

Gorodeski: Symptomatic and/or complicated cases are referred to a nephrologist/internist/cardiologist (depending on the patient's health insurance plan). Mild, asymptomatic cases are evaluated and initially managed by me, using a well-defined plan. This includes evaluation of the hypertension and baseline evaluation of the common target organs (including EKG, kidney function tests, and funduscopy); counseling for lifestyle modifications, including stress reduction, diet, and exercise; and defined and meticulous follow-up. HT is not considered a mode of prevention or treatment for hypertension, but women on HT are not automatically withdrawn from hormones. My overall management approach is the same as I described in response to the previous question.

Choi: Again, I think women need information and assistance in evaluating and changing potential behavioral factors for elevated blood pressure. Mild elevations may respond to improved health behavior. Reevaluation after a short period of implementation of reduced sodium, fat, and caloric intake, along with stress-management activities and increased physical activity, will demonstrate both the woman's ability to undertake behavioral change and the effectiveness of these measures.

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Which antihypertensive agents should primary care practitioners use as first-round therapy?

Havens: If hypertension is fairly mild, I would start with hydrochlorothiazide although there have been good data recently on the ACE inhibitors, particularly in showing how protective they are of the kidney. As a result, I really am leaning more toward the ACE inhibitors to start.

Kaunitz: I would rely on the PCP to do this.

Gorodeski: I would use diuretics, as long as patients are asymptomatic and do not have hypertension-related complications.

Choi: I also would yield this decision to the primary care clinician.

Which agents for the treatment of adult-onset diabetes should be considered first-round therapy? How do you monitor patients with adult-onset diabetes?

Havens: If their creatinine is 1.3 or lower, glucophage is definitely worth a try. I also start immediately trying to educate the patient about the importance of diet and exercise. It's important to do this at the beginning, because these patients need more than just medication. I emphasize to them that early intervention with diet and exercise really can make a dramatic difference.

I work in an environment where we have a lot of team players. For instance, we work with a PharmD who handles much of the education that we do with our diabetic patients, such as instructing them on how to use the glucometer and conducting the download from the glucometer each time they come in. In terms of monitoring, I monitor HbA_{1c} every 3 months and do a urine microalbumin about every 6 months in addition to the

patient's daily monitoring of her blood sugar.

Kaunitz: Again, I don't do this type of monitoring myself but rely on the PCP to do it. I will ask patients about their diabetes and ask about their medications when they come in to see me. If they tell me they are not complying fully with their medications for some reason or that their blood sugar is out of control, then I will make a note of it and report it to the PCP (and inform the patient that I am doing so).

Gorodeski: Patients with mild type-II diabetes mellitus are counseled for diet and exercise, and monitored for a defined period with monthly postprandial glucose or HbA_{1c} monitoring. In some cases I consider oral hypoglycemics, but usually those cases, as well as more advanced cases, are referred to an endocrinologist for initial institution of a treatment plan. Most frequently, those women will return and continue their follow-up and care in my office.

Choi: I would refer to the internist or family practice clinician for treatment and monitoring. I also counsel women that weight management and adequate physical activity can be important adjuncts to the management of elevated glucose levels.

Which factors would prompt you to consider referring patients to a cardiologist or endocrinologist for care?

Havens: We refer patients to a cardiologist for stress testing if they have ongoing chest pain. I often obtain a consult for difficult cases and co-manage them with the subspecialist. This is a win-win situation for both myself and the patient, as we both remain informed and involved in care.

Kaunitz: A patient who complains of chest pain is definitely going to be referred.

Gorodeski: A referral would be indicated in:

- Women symptomatic for CVD, including those with abnormal cardiac test/functions;
- Moderate or severe hypertensives (>200/120), hyperglycemics (fasting >200 to 250 mg/dl), hyperlipidemics/dyslipidemics, or women in those categories not responding to lifestyle modifications; and
- Women with a first-order family history of early morbidity/mortality from CHD.

Choi: I advise women who have severe dyslipidemia and strong family histories of early-onset CVD to see cardiovascular specialists. I refer women with diabetes who are morbidly obese and have uncontrolled diabetes to an endocrinologist who specializes in diabetes management. ■

Suggested Reading

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