

Women's Cardiovascular Issues: Editorial

John Grisham*

Division of Cardiovascular Diseases, University of California, USA

Editorial

Cardiovascular Disease (CVD) is a severe and under-recognized health problem among Southeast Asian women. With the exception of Singapore, the prevalence of cardiovascular risk factors such as hypertension, diabetes, cholesterol, physical inactivity, and being overweight or obese among women in the area has increased considerably. A lack of awareness that CVD affects men and women, as well as misunderstandings about the disease and a lack of adequate, local health literature, exacerbates the situation. National heart associations and other organisations have tried to promote healthy lifestyles and enhance heart health awareness. Similar prevention measures began in Singapore in the early 1990s, and the prevalence of cardiovascular risk factors has decreased. The governments of the region have begun to embrace appropriate preventative efforts and upgrade health-delivery systems, according to the Non-Communicable Disease Alliance. However, psychological, social, and cultural hurdles to women's cardiovascular awareness must be addressed before these programmes can be fully implemented and successful.

Cardiac disease is the leading cause of death among women. Women have historically been under-appreciative of these threats. When it comes to the age of presenting, there are considerable differences in the relative impact of risk variables. The 'gender advantage,' which was previously assumed to be due to female sex hormones, has yet to be explained. Similarly, the advantages of post-menopausal hormone treatment remain controversial. Risk can be reduced through reasonable risk factor management, but there is still a gap between calculated risk and proof of subclinical atherosclerosis, requiring a more proactive approach to risk reduction in women in particular. The dispute about statin efficacy in women is more likely due to problems with meta-analyses than to gender dimorphism. Rehabilitation reduces cardiac risk, but despite the fact that the advantages are the same for men and women, women are underrepresented in the programme. Recent allegations of "sex discrimination" in the treatment of heart disease highlight a more significant problem. The biology of heart disease in women, as well as the reasons for large inequalities in risk, diagnosis, and treatment outcome—medical or surgical—between males and females, are poorly understood [1].

Studies that are more focused on these concerns could benefit half of the patient population. In women, ischemic heart disease (IHD) is frequently ignored or misunderstood. As a result, many people who are at risk of bad outcomes do not receive the proper diagnosis, prevention, and/or treatment. Due to sex specific IHD pathogenesis, which differs from traditional models based on data from males with flow-limiting CAD blockages, this under-recognition exists. Women with identical symptoms are less likely than men to have obstructive CAD, and they are more likely to have coronary micro vascular dysfunction, plaque erosion, and thrombus formation. According to current research, more widespread non-obstructive CAD involvement, hypertension, and diabetes are connected to significant negative outcomes similar to those

reported in obstructive CAD. An important emerging paradigm is the concept of non-obstructive CAD as a cause of IHD and its unfavourable implications in women. This position paper discusses the current state of knowledge and information gaps, as well as management options that may be useful until further evidence becomes available. Pregnancy research is tough because it involves a 'sensitive' population that includes both the mother and the infant. The challenges of researching pregnancy in both normal and pathologic stages have contributed to the lack of pregnancy research. Most pregnancy studies were nonrandomized and retrospective until recently, reflecting existing clinical practise and professional prejudices [2].

Ethical and legal issues, research mandates, patient - related factors, the protracted nature of pregnancy, institutional commitment to research, interdisciplinary research and clinical collaboration, funding support, administration, and the degree of participation of national cardiac and obstetric and gynaecological societies are all barriers to research in pregnancy in developed countries. Due to the problems of obtaining consent, recruiting participants, and following up, even prospective observational studies are difficult to undertake. Misconceptions about research have limited women's participation in research. The longitudinal nature of prospective studies in pregnancy, problems associated with enrolling women before pregnancy and in the first trimester, and failure to understand the commitment required by the patient, as well as many social factors, have all contributed to increased drop-out rates during pregnancy, as well as difficulty with follow-up in the post-partum state. Studies with small sample sizes have been done as a result of these challenges, as well as a failure to augment funding help due to longer study periods than expected. Understanding the reasons for a patient's rejection to engage in research or withdrawal after giving their initial consent should make research participation more appealing to pregnant women [3-4].

The involvement of national societies in multicenter study planning and funding, inter - departmental and interinstitutional collaboration, institutional and interstitial funding support, and patient incentives are all critical for reducing study duration and ensuring adequate sample sizes for effective pregnancy research. Multicenter prospective study collaboration is more feasible in countries with National Health Service structures, such as those seen in Europe and Canada, than in countries with a fee-for-service system, such as the US. Involvement in prospective multicenter registries, as well as the use of telemedicine and handheld ultrasound technology, could improve clinical care for pregnant women in developing countries while simultaneously providing a platform for research throughout pregnancy [5]. Multicenter and even global registries supported by European cardiac societies have recently arisen, providing much-needed data on pathological diseases such per partum cardiomyopathy and pregnancy in congenital heart disease. Non-US countries are typically excluded from such studies, but emerging countries are increasingly participating. There is a shortage of study in the fields of pregnancy in connective tissue diseases, older women, post-chemo radiation therapy or organ transplantation, and HIV.

*Address for Correspondence: John Grisham, Division of Cardiovascular Diseases, University of California, USA, E-mail: gjohn@uoc.edu

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Conflict of Interest

The authors declare that there is no conflict of interest associated with this manuscript.

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