Disease Mongering: New Women's Guidelines for Heart Disease

The 2007 Guidelines for Preventing Cardiovascular Disease in Women were published February 20, 2007 in a special women's health issue of *Circulation*: Journal of the American Heart Association.[1]

According to this report as many women as men have heart disease and most women have risk factors that predict they are at high risk of a future cardiovascular tragedy. Regardless of the noble intentions of the American Heart Association and of the individual authors, one undeniable effect of these guidelines will be to bring more women into the heart disease businesses and will result in increased sales of medications and heart surgery.

Monger: derogatory term for dealer
Disease mongering: "... is the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments. It is exemplified most explicitly by many pharmaceutical industry-funded disease-awareness campaigns...Disease mongering turns healthy people into patients..."

Ray Moynihan, *PLoS Med.* 2006 Apr;3(4):e191.

Undoubtedly, women could be in better health and that would be best accomplished by focusing on the real causes of their troubles: diet, exercise, and habits. Although the Heart Association's new guidelines have merit, I would like to put them into a useful perspective and weigh in with my opinion on several key recommendations.

Heart Disease

The guideline's recommendations are for women to keep their LDL "bad" cholesterol below 100 mg/dL and if they are at high risk of heart disease the LDL should be kept below 70 mg/dL. Since in the real world, few doctors sincerely recommend effective dietary changes to accomplish these goals, most women will be unable to lower their LDL without medication. Undoubtedly, the pharmaceutical companies are pleased with this recommendation which will boost the sales of popular statins substantially.

Although the statins will make the numbers (cholesterol and LDL) look better, the benefits in terms of what women really want—a longer, healthier life without heart disease and strokes—remain unproven. I do not use statins in otherwise healthy women simply to make their cholesterol numbers lower.

I asked our keynote speaker from the February 2007 McDougall Advanced Study Weekend, John Abramson, MD, for his thoughts on the guidelines. He wrote to me: "As amazing as it may seem, the new *Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women: 2007 Update* are, once again, not evidence-based. These guidelines call for primary prevention of heart disease in women (meaning for women at risk of, but who have not yet developed, heart disease) with cholesterol-lowering prescription drugs (typically statins) based on LDL (or bad) cholesterol levels, depending on their level of risk. What these guidelines don't say is that there *has never been a single randomized controlled clinical trial—the gold standard of evidence-based medicine—showing that statins are beneficial for women who don't have heart disease or diabetes. None.* It's not just that there aren't any studies showing benefit. As described in my recent (2007) article in *the Lancet*,[2] clinical trials have included more than 10,000 women for primary prevention. The women in these trials randomly assigned to take statins developed no less heart disease than the women who took placebos ("sugar pills"). So how, you may wonder, could these guidelines that claim to be evidence-based, mislead millions of

women and their doctors into believing that statins will reduce their risk of heart disease, when the evidence from clinical trials shows the opposite? This gets at the critical issue facing Americans interested in optimizing their own and their families' health: medical knowledge itself has been turned into a commodity, produced mostly by the drug and other medical industries, for the primary purpose of maximizing corporate profits. What can you do to get good information? In this case, you can go to the *Therapeutics Initiative Letter on Statins*, and there you will find the best available information."

John Abramson, MD, author Overdo$ed America, clinical instructor Harvard Medical School.

I use statins in men and women who I "guess" are at high risk of cardiovascular disease. This guess is based on nearly 40 years of experience and what I believe the scientific research says. Unfortunately, much of that research has been heavily tainted by the pharmaceutical industries and is misleading. Thus, I retain the right to change my opinion on any drug therapy I may recommend.

When I am uncertain about my recommendations for the use of medications to lower cholesterol in one of my patients, I will sometimes order an ultrafast CT scan (Electron Beam Tomography-EBT) to add more information in order to help decide on treatment. If the scan shows a lot of calcium (indicating chronic inflammation from atherosclerosis), then I will tend to be more aggressive with medications (like statins or a combination of niacin and a cholesterol-binding agent—Colestid). If the calcium score is mild to moderate, I usually suggest a trial period of a couple of years with a good diet and then recheck the heart arteries with a repeat scan. If the heart arteries show no calcium, even with a high blood cholesterol level, then I feel comfortable that medication treatment can be postponed or avoided, since the elevated cholesterol seems to have been associated with little damage so far. My experience has been that with most cases of healthy women I have cared for, those with high cholesterol levels (250 to 350 mg/dl) almost always turn out to have clean-looking arteries on the heart scan—much to their relief, and mine. Hopefully, this "clean scan" result dose not cause them to become overconfident, and as a result, abandon their efforts to eat a healthy diet and exercise.

Hypertension

The 2007 guidelines recommend treating blood pressure more aggressively than I practice. They say, "Pharmacotherapy is indicated when blood pressure is equal to or greater than 140/90 mm Hg or at an even lower blood pressure in the setting of chronic kidney disease or diabetes (is equal to or greater than 130/80 mm Hg)." The 2004 British guidelines, which I follow, state, "Initiate antihypertensive drug therapy if sustained systolic blood pressure is equal to or greater than160 mm Hg or sustained diastolic blood pressure is equal to or greater than 100 mm Hg.[3]

The current Heart Association guidelines will cause doctors to overtreat hypertension and lower the patients' blood pressures to too low of levels with medications, and thus harms the patients. Research over the last 20 years clearly shows overaggressive treatment of blood pressure with medications kills. (See my Hot Topics, hypertension). The incidence of heart attacks, death, and/or stroke was three times higher for patients with a diastolic blood pressure (the lower number) of 60 mmHg compared to a person with a pressure of 80 to 90 mmHg (when treated with medications to lower blood pressure).[4] When I treat high blood pressure with medications, I am careful to not lower the diastolic (bottom number) below 85 mmHg.

Aspirin

Possibly the most controversial recommendation in these guidelines is for the use of aspirin by all women for the prevention of stroke (not heart attacks). The 2007 guidelines state, "Of note is that aspirin therapy should be considered for all women for stroke prevention, depending on the balance of risks and benefits."

To have women of all ages take a baby aspirin daily to prevent stroke is too risky in my opinion. I recommend one baby aspirin daily for men and women who have a high risk of having a stroke or heart attack. These would include people with a past history of a thrombotic stroke, TIA (transient ischemic attack), carotid endarterectomy, heart attack, angioplasty, or bypass surgery. For people without these unhealthy past histories, the risks of the aspirin outweigh the benefits. The primary risk is bleeding, which can be lethal and/or require transfusions.

HRT and Supplements

With these updated guidelines, hormone replacement therapy, selective estrogen receptor modulators (SERMs—like Evista), antioxidant supplements (such as vitamins E, C, and beta-carotene), and folic acid are no longer recommended to prevent heart disease in women. I have held this view for a long time, since the science clearly says these treatments increase a woman's risks of troubles from heart disease to cancer, and even more death.

The guidelines do recommend fish oil, "As an adjunct to diet, omega-3 fatty acids in capsule form (approximately 850 to 1000 mg of EPA and DHA) may be considered in women with CHD, and higher doses (2 to 4 g) may be used for treatment of women with high triglyceride levels." I do not recommend these omega-3 fats because they have many adverse effects, such as weight gain, an increased risk of bleeding, and immune system suppression. Not to mention the hazards to the poor fish.

Exercise

The guidelines recommend that, "Women should accumulate a minimum of 30 minutes of moderate-intensity physical activity (eg, brisk walking) on most, and preferably all, days of the week. Women who need to lose weight or sustain weight loss should accumulate a minimum of 60 to 90 minutes of moderate-intensity physical activity (eg, brisk walking) on most, and preferably all, days of the week."

The reason for so much exercise is that the Heart Association recommends a diet too high in fat and calories—and as a result, the only way to lose weight is to exercise intensely. This much exercise takes a large amount of time and effort, and expectedly, compliance will be low. Following a low-fat diet such as the one I recommend (especially the McDougall Maximum Weight Loss Program) results in effective weight loss even with minimal to no exercise. Once the diet is learned, compliance is high—the foods taste great and the benefits are huge.

Diet

The guidelines recommend, "Women should consume a diet rich in fruits and vegetables; choose whole-grain, high-fiber foods; consume fish, especially oily fish, at least twice a week; limit intake of saturated fat to less than10% of energy, and if possible to less than 7%, cholesterol to less than 300 mg/d, alcohol intake to no more than 1 drink per day, and sodium intake to less than 2.3 g/d (approximately 1 tsp salt). Consumption of *trans*-fatty acids should be as low as possible (eg, less than1% of energy)." With each new guideline the American Heart Association seems to be getting closer to what Nathan Pritikin tried to teach them more than 25 years ago—a plant-food-based diet is the foundation to preventing and reversing heart disease.

How could scientists understand that saturated (animal) fat and cholesterol cause heart disease and strokes, and then recommend that people simply reduce the amounts of these toxins? Don't they believe their own findings? Or do they not believe patients are capable of following a truly healthy diet—since they themselves can't?

As you know I have no hesitation about recommending a diet with no animal fat and no cholesterol—in fact, I eat that way myself. Fish is not health food. It is high in fat, cholesterol, and environmental contaminants and is also deficient in dietary fiber, carbohydrate, and vitamin C. The methylmercury content is so high in many kinds of fish that benefits for heart disease are entirely negated.

My Overall Conclusions about the Guidelines

The guidelines represent progress, but I do believe they are being influenced by the pharmaceutical industry to build their market share by making more women sick with their broader definitions of high cholesterol and high blood pressure. Treatments are the bread and butter of doctors, and of drug and device companies.

Money and the personal dietary habits of the advisory panel set aside, these guidelines would come down heavily on treating the cause of cardiovascular disease, rather than treating it with medications. Unfortunately, delays mean lives are spoiled and shortened. The divide between the potential benefits of following current scientific knowledge about a low-fat, no-cholesterol diet and what the American Heart Association Guidelines, and most practicing doctors, recommend remains costly for women, and men.

References:

1) Mosca L, Banka CL, Benjamin EJ, Berra K, Bushnell C, Dolor RJ, et al, Evidence-Based Guidelines for Cardiovascular Disease Prevention in Women: 2007 Update. *Circulation.* 2007 Feb 19;

2) Abramson J, Wright JM. Are lipid-lowering guidelines evidence-based? *Lancet.* 2007 Jan 20;369(9557):168-9.

3) British Hypertension Society guidelines for hypertension management 2004 (BHS-IV): summary. *BMJ.* 2004 Mar 13;328(7440):634-40.

4) Messerli FH, Mancia G, Conti CR, Hewkin AC, Kupfer S, Champion A, Kolloch R, Benetos A, Pepine CJ. Dogma disputed: can aggressively lowering blood pressure in hypertensive patients with coronary artery disease be dangerous? *Ann Intern Med.* 2006 Jun 20;144(12):884-93.