Both men and women will agree that women are the better half of most relationships and have the biggest hearts. But does that also translate to a higher than expected incidence of cardiac disease?

Most think of occlusive heart disease as occurring in men predominately, but heart disease is now the leading cause of death in women throughout the world. In fact, the American College of Cardiology states that more women than men die of cardiac disease each year in the United States.

One of the problems for doctors with women and coronary disease is that women often have atypical symptoms. Instead of the usual crushing chest pain associated with nausea, sweating and a vice-like feeling, affected women often present with shortness of breath as a primary presenting complaint. Doctors are likely to ascribe chest pain in women to stress, and sometimes think the pain has a gastroenterological source such as heartburn or gall bladder disease. Only about one in three women experience typical anginal pain as their first sign of cardiologic disease—shortness of breath, fatigue and weakness are the primary triad of symptoms for women.

Women often present more diagnostic dilemmas in presentation than do men. They are twice as likely to have clean coronary arteries when a catheterization is done. The difference has to do with such factors as vasospasm (when the vessel closes from spasm but is not occluded by calcium) or microvascular disease, where small arteries are diffusely affected and the larger vessels look comparatively clean. Exercise testing, or stress tests, are also proportionally more false positive in women than in men, so at times doctors will ascribe a result to a “false-positive” that truly turns out to be the real thing. In those cases a SPECT scan (computerized tomography) may yield the answer, but it, too, may have false results because of breast shadows.

Microvascular angina affects women more than men, and more than 70 percent of those who carry this diagnosis are women. A woman may present with all the classical signs of cardiac compromise, but a catheterization to look at her heart vessels is relatively normal. This condition is called syndrome X and generally is present at younger ages more frequently than in the elderly. It is a tough diagnosis to make and has to be considered by experienced cardiologists using more sophisticated methods of measuring cardiac flow reserve. Unlike when larger vessels are obstructed and cardiac stenting or bypass is used, medical treatment is more effective in helping affected females.

Of course women suffer from the traditional cardiac syndromes such as cardiac blockage, plaquing and dissection of coronary arteries. In these cases, prompt recognition and treatment of symptoms is of paramount importance. Chest pain should be taken as seriously in women as in men, and investigated even more thoroughly when the
symptoms are real but traditional testing hasn’t turned up a definite answer.

One other condition worth mentioning that affects women more than men is one called stress cardiomyopathy. The more common term is “broken heart syndrome.” It’s a condition that affects mostly postmenopausal women and is associated with sudden physical or emotional stress. Affected women present with all classical signs of a heart attack or blockage but testing fails to reveal a demonstrable cardiovascular disease. The cause is not yet fully known, although sudden rupture of cardiac plaque is suspected. Most patients with this condition improve over time and recurrence is quite rare, with subsequent testing usually being quite normal.

Underwriting women with cardiac disease parallels that of men, although women have historically done better with risk factor modification and compliance with treatment. Additionally, since many of the conditions don’t have marked cardiac obstruction, medication is very effective in preserving a heart that has not sustained the physical damage associated with a larger heart attack.

The biggest question for underwriters is suspecting underlying disease in a female who has had typical symptoms but who has not had the diagnosis of cardiac disease made at the time of application. Sometimes additional testing is needed to certify a non-cardiac cause and the ability to issue at a more preferred rate.