

Gender and Cardiovascular Disease

According to the World Health Organization, atherosclerotic cardiovascular disease is the leading cause of death in both men and women. The Argentine Journal of Cardiology dedicated this entire issue to the relationship between gender and cardiovascular disease, in order to discuss the similarities and differences between sexes, and to broaden the debate with contributions from original papers, national and international editorials, special articles and reviews on this subject. Cardiovascular disease, especially atherosclerosis, has a different impact according to sex, even when individuals have the same prevalence of coronary risk factors. Its deleterious effect is manifested in women at a later stage, as in the case of acute myocardial infarction (AMI), whose average age for presentation is 10 years later than in male patients. Also, the global prevalence in women is only 1 out of 4 infarctions, (2) but when separated by age, this ratio is reversed after 70 years of age. In 2005, AMI mortality rate in Argentina was four times higher in men between 35 and 64 years than in women (13 vs. 52 per 100000 inhabitants); however, mortality rate increases more than 15 times in women older than 65 years (211 per 100000 inhabitants). (3) This biological specificity of AMI in women, in addition to powerful prevention campaigns carried out to detect gynecological tumors, have focused on women of childbearing potential and could have had an incidence in the fact that heart disease was considered a "men's disease" in the last century.

This bias leads to delayed or wrong diagnosis, and ultimately impacts on therapeutic strategies, with serious consequences for women's health. In 1991, Bernadine Healy coined the name "Yentl syndrome" for this situation in an editorial of the prestigious journal *New England Journal of Medicine*. (4) This name is derived from the XIX century heroine of the story by Isaac Bashevis Singer, (5) Nobel Prize in Literature 1978, called Yentl, who had to disguise herself as a man to attend school and study. This editorial points out that being 'just like a man' has historically been a price women have had to pay for equality (direct quotation from the original article). In the 1997 surveys, only 30% of women believed that cardiovascular disease was the main cause of death and after the 2006 Go Red for Women campaign this perception increased to 55%. (6) However, this was not the case in Argentina, as evidenced by the survey conducted on that same year by the Cardiology Foundation under the Heart and Woman program, which is fully discussed in the present issue of the Argentine Journal of

Cardiology (RAC). Finally, the analysis of two original articles demonstrates that, in Argentina, therapies for acute coronary syndromes show a gender bias by sub-optimal treatment in women.

Gender inequality in health care has been described as delivering the same standard of care for both men and women when their gender needs are different, or delivering a different standard of care when their needs are the same, which promotes gender stereotyping for health care models.

Psychosocial and cultural aspects should also be taken into account in determining coronary risk in all its complexity. In our present area of debate, the differential analysis on how men and women build their way of being and going around the world, the specific social demands and associated living conditions should be included in the practical and conceptual network focusing on the various health issues. Moreover, the fact that incidence of ischemic heart disease in women has increased over the past years is internationally accompanied by understanding specificity in women for this type of problem. For that reason, the present issue of the Journal shows advances in the link between psychosocial and cultural factors by gender, and their relation to coronary heart disease in an important and special article, which reviews research on gender perspective carried out by the University of Buenos Aires. This research was conducted from an approach associating living conditions and the subjective construction of gender-oriented modes in our society, that establish 'generated' ways of living, and therefore, of becoming sick, consulting, being cared for, and dying. Thus, information about construction of masculinities and femininities in modernity and their impact on heart health are included, in order to have tools that can be added to biological specificities. Through this information, we can observe the significance that differential and specific construction modalities of subjectivity associated to living conditions can have in men and women, when elements related to subjectivity and gender construction are incorporated to the 'stress' indicator.

Dr. Débora Tajer
Dr. Adrián Charask^{MTSAC}

REFERENCES

1. Ferrante D, Virgolini M. Encuesta Nacional de Factores de Riesgo 2005: resultados principales. Prevalencia de factores de riesgo de enfermedades cardiovasculares en la Argentina. *Rev Argent Cardiol* 2007; 75:20-9.
2. Sosa Liprandi MI, Racki M, Khoury M, Villarreal R, Cestari G, Mele E y cols. Crisis económico-financieras en la Argentina: ¿un nuevo factor de riesgo de mortalidad cardiovascular? *Rev Argent Cardiol* 2012; 80:137-44.
3. Gagliardi J, Charask A, Higa C, Blanco P, Dini A, Tajer C, por los Investigadores del Consejo de Emergencias Cardiovasculares y Área de Investigación SAC. Infarto agudo de miocardio en la República Argentina. Análisis comparativo en los últimos 18 años. Resultados de las Encuestas SAC. *Rev Argent Cardiol* 2007; 75:171-8.
4. Healy B. The Yentl Syndrome. *N Engl J Med* 1991;325:274-5. <http://doi.org/dd8kk6>
5. Yentl the yeshiva boy. In: Singer IB. *An Isaac Bashevis Singer reader*. New York: Farrar, Straus and Giroux; 1971. p. 135-66.
6. Mosca L, Mochari H, Christian A, Berra K, Taubert K, Mills T, et al. National study of women's awareness, preventive action, and barriers to cardiovascular health. *Circulation* 2006;113:525-34. <http://doi.org/fh8z25>