The Heart of Women

Women's experience of myocardial infarction—Ann Gutsell

OTAGO POLYTECHNIC
Te Kura Matatini ki Otago

Introduction

In New Zealand 2013, 2920 women died of heart disease, equating to 8 women a day or, 56 a week (Ministry of Health, 2014). Women present differently to men with cardiac symptoms and can have a prodromal period of up to a month before presently acutely. Women also delay seeking treatment, thinking they aren't as susceptible as men.

There is still a tendency to believe that heart attacks are a male problem and diagnosis is based primarily on the descriptive experience of white, middle-aged men (McSweeney, J., Cody, M., O'Sullivan, P., Elberson, K., Moser, D., and Garvin, B. 2003), yet studies show two-thirds of women world-wide, who experience heart attacks, have had no history of chest pain (Heart Foundation, 2016).

Reviewing literature that highlights these sex-specific symptoms reported by women, will aid me in my future nursing practice, by incorporating that knowledge when conducting a comprehensive patient assessment.
Research question: **" How do women experience myocardial infarction?"**

Main symptoms reported by women

Unusual fatigue	70%
Sleep disturbance	48%
Shortness of breath	42%
Chest discomfort	29% *

* Chest discomfort is also described as:
Pressure, fullness, sharpness, and burning

Reasons why women delay seeking help

They don't believe they're having a 'heart attack'

They don't recognise the symptoms

They have commitments—work, children, family

They have other problems that mimic the symptoms

They don't want to inconvenience anyone

Recommendations

There is a need for women to understand, educate themselves, and others in the sex-specific symptomology of cardiac disease. Women need to become more pro-active in being aware of symptoms and seeking help.

For all health professionals to have a better, more in-depth understanding of women's cardiac health, with nurses playing a strong role in educating and supporting women at risk of ischaemic heart disease and myocardial infarction (Sjostrom-Strand, Ivarsson, and Sjoberg, 2011).

For there to be multi-cultural, multi-language resources, education streams, and advocacy by nurses and health professionals to aid women in making better health choices in their own cardiac care.

Conclusion

Statistics show ischaemic heart disease is responsible for largely preventable and premature deaths of women in New Zealand. This is paired with a limited understanding by women of what is our highest health risk.

Women world-wide and in New Zealand need to understand the full impact of heart disease and what the symptomology is for women. All health professionals should encourage women to be pro-active in knowing their current cardiac health status, and what can be done to improve and maintain it.

Including this knowledge into a nursing practice when conducting patient assessments, will help educate and empower women as their own 'health professionals' and in time, reduce the current mortality statistics.

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Rationale

In view of New Zealand's high statistics for women dying from myocardial infarction (MI), there is a need for strong health promotion and education to be delivered to New Zealand women of all races, cultures and ages, to help reduce these mortality figures (Ministry of Health 2014).

Focusing on women's health, nurses need to become aware of the way a woman experiences symptoms, and the anomalies between men and women in MI symptom description and presentation (McSweeney, et al., 2003). From initial assessment of women, be it in the community, homes, or in hospital care, knowing that women can experience prodromal symptoms up to a month before any cardiac event, can lead to earlier interventions and treatment for women at risk of MI.

Presenting this in an easy to follow medium such as a poster, helps the viewer to understand the facts quickly. Relevant information is highlighted using placement. Colour use and images emphasis what the article is about and helps relay a visual connection to the information.

PECOT Category	Information relating to question	Explanation
Population	Women – from age 20 + who have also either: • been patients after experiencing AMI • interviewed about knowledge of IHD and lifestyle risk factors • Asked about general knowledge of CHD • Are health professionals	This large section is needed to cover the varying biopsychosocial factors and changes as women age and how this affects her likelihood of developing IHD How knowledge of IHD changed post event The current need for more understanding about the sex differences and how that shows in symptomology for IHD
Exposure (intervention)	• Women who have been interviewed, post -acute myocardial infarction hospital admission and treatment. • Women's knowledge about heart health, risk factors and barriers	First-hand experience and description
Comparison/Control	Men – who have experienced AMI	Highlights the differences between symptoms experienced, expressed and assessed by health professionals
Outcome	Greater understanding of women about IHD, modifiable risk factors, sex-specific symptomology, accurate assessment and treatment. Lowering the statistics of deaths of women caused by IHD, in New Zealand and worldwide	Application in the clinical field of understanding sex-specific symptomology, in regards to more comprehensive assessment of women. Better quality of life for women from a younger age, and into older age if risk factors are reduced for death from IHD.
Time	This was difficult to define, though lon-gitudinal studies ranging from 1997 – 2012 had been included in this review Clinically, was important to survey and interview women who had experienced AMI as soon as possible, to get a relevant and current perspective on the event.	Women of all ages were interviewed and studied. The timeframe around experiencing IHD ranged from a few weeks before the event, to rehabilitation and recovery up to 5 years later.