

Women and Cardiovascular Risk Factors
Webcast
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Dr. Marla Mendelson

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Introduction

ANDREW SCHORR:

This is Andrew Schorr from Patient Power, and thank you for joining us for an interview on a very important health topic to women, and that is about heart disease, your risks, where are we now in prevention, treatment, should you have a heart problem, concerns about other members of your family, your daughter, your mom, etc. We're going to talk about all that. And thank you so much for our partnership with Northwestern Memorial Hospital and today, in particular, the Bluhm Cardiovascular Institute at Northwestern Memorial Hospital.

And with us on the line is Dr. Marla Mendelson. And she is the director of the Center for Women's Cardiovascular Health with the Bluhm Cardiovascular Institute.

Dr. Mendelson, thanks for being with us.

DR. MENDELSON:

Oh, my pleasure

ANDREW SCHORR:

So, many women, I know we worry about so many things, and certainly women, if you went to a woman on the street and say What's your biggest health worry, she would say breast cancer.

DR. MENDELSON:

Yes.

The Leading Cause of Death in Women: Heart Disease

ANDREW SCHORR:

And certainly that's a concern. But the truth is their biggest risk of dying is from what?

DR. MENDELSON:

Heart disease, cardiovascular disease, and that's all types of cardiovascular disease including stroke. The risk of a woman dying from a form of cardiovascular disease, and in this country the most common form is coronary artery disease, the blockage of the arteries that causes heart attacks, that risk is twice the number of all cancer deaths combined.

ANDREW SCHORR:

Wow.

DR. MENDELSON:

That's the bottom line. We're talking one in three women.

Risk Factors: Weight, Hypertension, Diabetes & Smoking

ANDREW SCHORR:

Wow. Now what leads to this? Certainly, I know in our population we have a weight problem, and we have a diabetes epidemic, maybe more than 15 million people, and I know we'll talk during the program about how that relates to heart disease. And also so many women smoke or did smoke. So take us through, what are these--what's going on that makes this so risky for women?

DR. MENDELSON:

Well, women, first of all, thought they were immune to heart disease. They thought it was a man's disease, a disease of older age. And in one small part that's true. After menopause a woman's risk increases considerably for cardiovascular disease, because the estrogen that the ovaries secrete before menopause does exert a cardio-protective effect. But with the loss of estrogen at the time of menopause they lose that protective effect. So that certainly is an aspect of the risk.

But certainly the other cardiovascular risk factors are equal opportunity offenders. Hypertension. In fact, as a woman gets older she becomes at a higher risk for hypertension, particularly the African-American woman.

Diabetes, the woman with diabetes actually doesn't get that protection. She's at the same risk as her male age counterpart at any point in her life if she's had diabetes for many years. So diabetes is almost a coronary artery degree equivalent. Meaning you have to assume that somebody has coronary artery disease until proven otherwise when they have long-standing diabetes.

Smoking is a risk factor. Despite what we know - all the education in the schools and other educational public programs, there is still--you go past any public place, hospitals, I have to say, high schools, and you'll see smoking out there.

And then family history. That can't be discounted. You can do everything right but just not have picked the right parents, and you are at risk because a member of your family had coronary disease at an early age. And that can be a male relative if you're a woman or a female relative, it doesn't matter.

ANDREW SCHORR:

Now our weight problem, just obesity, in and of itself, is that a problem?

DR. MENDELSON:

Obesity is a huge problem. It is an epidemic in this country affecting younger and younger people. It is particularly a potent risk factor for women. It has been shown that women who gain more than 20 pound over what they weighed when they were 18 have an increased risk of cardiovascular disease. Well, that covers a lot of women in this country.

ANDREW SCHORR:

Okay. So there are obvious things we could say. How do you avoid being in that situation? Well, don't smoke or stop. And I want--we'll get into this in greater detail. If you have diabetes, manage it.

DR. MENDELSON:

And take care of all your other risk factors.

ANDREW SCHORR:

Right. If you're overweight to try to get on a healthier diet and exercise that can help you slim down and maintain it. And, of course, if you have a family history get checked too. Understand your risk and how you need to be followed for that and how you need to live your life.

Let me go back to smoking. If a woman smokes, she says Oh, it's so hard to quit and it's too late now. I've already done the damage. You know, I'll just never get there, and, yes, I know it's a factor in lung cancer and it's a factor in heart disease, but this is too tough. The damage is already done. What do you say?

DR. MENDELSON:

The only part of that I will agree is that it is tough. It is tough to stop smoking. However once a person, man or woman, stops smoking over time they start reaping the benefits, first in the lung and then with other organs in the body. So it's never too late to stop smoking. And it is very difficult to do. It's probably harder than losing weight. It doesn't mean once you stop smoking you're going to magically become obese. That doesn't necessarily have to happen if you adopt a healthy lifestyle.

I think a lot of people smoke, so they tell me, because of stress. Personally, I think exercise is a better stress reducer. So if you take away smoking and replace it with a healthy activity, instead of--chocolate, then you're way ahead of the game.

ANDREW SCHORR:

And just so we understand, when we say smoking is a threat to your heart, what's

going on medically? How does it do such damage?

DR. MENDELSON:

It affects the arteries and the linings of the arteries that supply blood to the heart muscle. It increases heart rate. It actually has toxins that are released within the bloodstream. And it's a long process, and of course it's addictive. So it's a very difficult process and it's a vicious cycle.

The Role of Exercise

ANDREW SCHORR:

Let's talk about exercise. You know, every year, the new year, all the gyms are advertising on TV, join our health club etc., and many people do. And it's part of their new year's resolution. But for heart health, it doesn't have to be such a dramatic change. It doesn't have to be like going to boot camp, does it? It can be just almost what we'd say is a slight or just a moderate amount of exercise walking or going up the steps or parking your car further when you're going somewhere, isn't it, and just make that part of your life.

DR. MENDELSON:

There's two types of exercise. There's preventive exercise, which everybody on the planet should be doing and that's walking 30 minutes every day. And that's pretty much distilled so that it's easy to do, and doing that type of equivalent.

Once you start talking about therapeutic exercise, what I refer to as therapeutic exercise, exercise to lose weight, exercise to lower your cholesterol, exercise to lower your blood pressure, that type of exercise you're going to have to do something pretty vigorous with an elevated heart rate, probably at three to five hours a week in addition to the walking. So that's what we talk about with the exercise.

And I really don't care what people do as long as they get their heart rate up. And it doesn't have to be expensive or particularly athletic. It just needs--the heart rate needs to be elevated. You need to be a little breathless but you need to be able to talk in at least partial sentences, and you need to do that and commit to that. And just committing to exercise is a big deal.

It doesn't all have to be done in one sitting. It can be 15 minutes and 15 minutes for the walking. But it needs to be done. There are programs out there. The Curves program where they move from one machine to another, it's a great start for an exercise program. And I will take anything to get people moving.

ANDREW SCHORR:

I know you hear about it all the time with women who you see there at the clinic of all the reasons why they didn't. So that's the point I'm trying to get to. It doesn't have to be so daunting. It could be walking briskly with the dog or walking the mall with your girlfriend or daughter. Whatever gets you going. As I said, maybe not using the elevator. If you work, you know, if it's not on the top floor are there a few floors you can walk up? Are there basic things you can do? Go to a restaurant a little further for lunch. Make that walk a little longer. These are things that people could incorporate into their day.

DR. MENDELSON:

Absolutely. These are all very, very good ideas. Simple things that people can do just to add more fitness to their life. It's a small thing but it goes a long way.

Diet: What to Avoid and What to Embrace

ANDREW SCHORR:

Now, our American diet attacks all this. And that is because my understanding is what's happening when you're not getting the heart pumping a little more vigorously there's kind of crud that's forming over many years in our pipes, if you will, and we're not flushing it out with a higher rate of blood flow and pumping. And that's coming--not always, but it's coming to some degree from our diet. What are the big offenders in our diet that you wish people would change?

DR. MENDELSON:

Well, let me just clarify. The cholesterol, which is the element of the diet, the fat which deposits within the arteries and blocks the arteries, exercise helps the body metabolize and get rid of cholesterol. Exercise also makes the body more efficient, so the heart doesn't have to work that hard. It makes the muscles more efficient, so it doesn't--the heart doesn't have to increase its pumping and work. So it takes a load off the heart with exercise.

Our diet, our diet is horrible. And it's difficult. It's made difficult. What is the food that you can grab and eat on the street if you're so inclined? It's potato chips. And it's things that have a lot of fat in it. Things that have a lot of sugar in it. Everything that's actually healthy does take a little more time. It takes time to peel the fruit and cut the fruit and wash the vegetables, but obviously it's worth it, and we need to try and get more convenience foods that are healthy.

And I'm not sure we need to legislate all that. We just need to give people more options and choices. I think that starts in the home. It starts in the schools. When you go into some cafeterias there is not a single healthy option offered to the children during the day.

ANDREW SCHORR:

That's for sure.

DR. MENDELSON:

And you need to start there. Because people are going to eat what you put in front of them, and it's a matter of what you put in front of them. Nobody has to have cookies in their house. It's not a rule.

ANDREW SCHORR:

That's right. Dr. Mendelson, you know, in sort of heartland America, around Chicago, though, a lot of ethnic groups with sausages and other recipes from the Old Country, let's face it, some of these are not the greatest for your heart.

DR. MENDELSON:

No, the highest rates of hypertension and cholesterol are actually in Eastern Europe. And then the lowest rates are in Japan and China, although there's hypertension in Japan and China, a significant amount. Yes, there are ethnic foods, but I think what happens is a lot of ethnic groups come here and we've actually even perfected some of the high fat foods and made them more accessible. When you talk about ethnic food that take more time and love to cook, that still takes time and love to cook.

The other big thing is portions. You can eat fairly widely but you shouldn't eat a lot of food. And that's the other thing too. Our portions have been escalating in our country. Just take the poor lowly bagel and how that has changed in size. It looks like it's been injected with steroids. It's huge.

ANDREW SCHORR:

Right. A slice of pizza. Everything we want super sized.

DR. MENDELSON:

Right. And so that is--it's ridiculous, and people eat what's in front of them and then they're just not offered the right choices. You can't legislate a lot of that, you just have to retrain people. And I think it just has to start in childhood. It's hard to retrain people, craving for sweets. Those are very difficult things to do. Not impossible, but they're difficult. And we need to help people facilitate that, if they really want to try.

ANDREW SCHORR:

Now, when someone comes to the clinic I understand you're not a big fan of red meat.

DR. MENDELSON:

Personally, no.

ANDREW SCHORR:

So help us understand what you recommend to women who are your patients as a wise diet.

DR. MENDELSON:

I say fish--there's a list. The list of what you should eat is--because you can go through telling people what they shouldn't eat and I start telling people what has a lot of salt in it and what they shouldn't eat, and I see by their face that I'm describing their entire diet.

ANDREW SCHORR:

Right.

DR. MENDELSON:

But I tell them what they should eat. The list is fish, fowl, fruits, and vegetables. And if it's not on that list, don't eat it. Again, I make it simple. I've been in practice a long time. I've heard every single excuse there is. But if you stick to that list I think you're okay. Yes, you need fiber in your diet. You need other types of things in your diet periodically, small amounts. But that's a good rule of thumb. And when you look at any diet that's pretty much what they're telling you. Lots of water, lots of exercise and eating lean foods is very important.

Genetic Link with Heart Disease

ANDREW SCHORR:

You can save our listeners a lot of money who try every new diet under the sun, struggle with it, and of course in the meantime maybe they're not helping fight the heart disease that could develop over many years in themselves.

Let's talk about family connection. Okay, so a woman has a mom or a dad who died in their 50s, maybe even in their 40s, had a heart attack. And as they start to get in their 40s or their 50 they say Oh, my. Is this what runs in our family and is going to happen to me? So tell us about the connection with family history and someone's risk for heart problems.

DR. MENDELSON:

Well, as you describe, it's a family member, a parent, a brother or sister, or a child, even, to look at it the other way around, who had disease in men before age 40 to 45 and in women before age 50 or the menopausal years. So that would be a red flag. And you can't do much about that. You should be aware that you have that risk, and then you do a very careful inventory of all your other risk factors and make sure you're doing something to take care of all of those.

Now, there may have been extenuating circumstances. It doesn't mean just because your father had a heart attack at age 35 that you're going to have one, especially if you look at differences in lifestyle, but it doesn't mean that it's not going to happen. So you need to be mindful of it and do what you can do.

ANDREW SCHORR:

Okay. So that would be a discussion, though, for a woman with her doctor to say, I want to point out in my family this has happened and I worry about it. And then see whether they should be followed more closely, or what happens next?

DR. MENDELSON:

Well, I think a clinician is going to do an inventory of a woman's risk factors. There's a lot of resources on the internet available for people to kind of self assess themselves before they go see the doctor so they make sure issues are brought up. But they can--a physician should run through--or any health care provider should run through these risk factors and see if there is any red flags.

ANDREW SCHORR:

I should mention that right on the American Heart Association's website, heart.org, there is a Take the Checkup quiz, basically.

DR. MENDELSON:

That's right. And on the gored.org site from the Heart Association there's one for women. It's called The Checkup.

ANDREW SCHORR:

Right.

DR. MENDELSON:

And there's a national initiative to get a million women to get on there and assess themselves for cardiovascular risk.

Diabetes

ANDREW SCHORR:

Well, it would seem like that could maybe--that sort of step is the beginning of making a dent. Just awareness and taking a look at your personal situation is the first step in trying to lower your own risk. Now we talked about family history. We talked about diet. We talked about exercise.

What about diabetes, because we said that that's such a--it certainly goes in many cases with people becoming obese, but it is an epidemic in this country. Why is diabetes such a risk factor for heart disease?

DR. MENDELSON:

Diabetes attacks the blood vessels. It affects the blood vessels and promotes early development of blockages in both large and small blood vessels. And that's in the heart, and actually it's throughout the body. It's in the blood vessels of the brain. It's in the blood vessels of the kidneys. It can affect the nerves. It can affect the blood vessels that go down to the legs. So it is a very all-encompassing and significant disease. And we believe that with good control we can control this vascular blood vessel disease which can be the lethal portion of this. So it is a very difficult disease. It can be controlled, and it's important to get it under good control.

But as you pointed out, it does go hand and hand with adult obesity. So I have seen patients who have had significant weight loss and have actually been able to stop medications for diabetes. So we're talking about significant weight loss.

ANDREW SCHORR:

Let's talk about this. My understanding is that if someone has diabetes that there are numbers--and we'll get into that a little later -- blood pressure and cholesterol numbers, should be to such a level that it's like the rigidity that you're having with somebody who's had a heart attack. In other words, you want that tighter control like somebody had already had a coronary event. Is that right?

DR. MENDELSON:

Absolutely. In fact, as you I mentioned earlier, diabetes is considered to be a coronary artery disease equivalent, meaning we assume they've had coronary artery disease. So whether they've had an event or not--and many diabetics can get silent heart attacks where they don't get classic symptoms which result in damage to the heart that they don't even know about. So we do take a much stronger stand in the patient with diabetes because they already have a major, major problem. And we do assume they have coronary artery disease and we treat the other aspects much more aggressively.

Cholesterol: What You Need to Know

ANDREW SCHORR:

So lets talk about numbers. Somebody's coming for a checkup with you. What do you want to see their blood pressure be, and what do you want their cholesterol to be? And help us understand this about good cholesterol, bad cholesterol. What are the numbers?

DR. MENDELSON:

Well, if they are diabetic, their blood pressure needs to be below 130 over 80. If they're not, it should be below 130 over 85. So somebody with blood pressure of 140 over 90 has high blood pressure, just starting there. So we would like the blood pressure to be 120 over 70 because there's been some data that shows that above that level they are at potential risk. And yet it's not indicated to treat the blood pressure at that level yet, but certainly they need to be addressing issues such as salt in the diet, exercise, weight loss. Those are the type of issues we look at before they need to be treated.

And then we've got lots of medications to treat high blood pressure. We like to make sure somebody has high blood pressure at three individual readings and make sure it's not just a situation of meeting a new physician.

As far as cholesterol, cholesterol is usually checked. We like to check it in the fasting state. And usually what's reported are four numbers: the total cholesterol; the LDL, or the bad cholesterol; the triglycerides, which reflects basically the carbohydrates in your diet and may be elevated in diabetes; and the good cholesterol.

Now, the bad cholesterol, the LDL that should be--for sure, it should be below 130, but it would be better if it were below 100. And if somebody has had coronary disease the lower the better, but certainly below 70. And every year that number keeps dropping down.

HDL should be as high as you can get it. And the way to raise your HDL is with diet and exercise, basically. And the HDL as high as you can get. Women, premenopausal women, have high HDL and some of that is due to estrogen, and then with the loss of estrogen that can fall. But, again, you've got to keep it up with diet and exercise.

ANDREW SCHORR:

Okay. So what are the numbers for somebody who comes in to see Dr. Mendelson and gets a gold star?

DR. MENDELSON:

Cholesterol, less than 200. HDL, 80, and that's a pipe dream. LDL, 100. And the triglycerides should also be low because it's a fast example.

ANDREW SCHORR:

Okay. And the blood pressure?

DR. MENDELSON:

Blood pressure, 110 over 70.

ANDREW SCHORR:

Okay. I want my female friends to get a gold star from you for that.

DR. MENDELSON:

Well, you know, it applies to men too.

ANDREW SCHORR:

Okay. Right.

DR. MENDELSON:

This is just good medicine.

How Heart Disease Kills

ANDREW SCHORR:

Now, let's go on. So let's say somebody--we know that many people are at risk and we know it's the number one killer for women. What is usually happening? Is it a sudden heart attack? Is it a blockage that develops and somebody ignores the signs? When we say, Boy, we lost Sally, we lost Barbara. Typically, how is this happening?

DR. MENDELSON:

It can happen in a variety of ways. Plaque develops in the arteries from the time we're teenagers. And sometimes that plaque becomes unstable, and it will rupture. And it spews out all the pieces that are within it, the cholesterol, some other cellular debris. And what that does is it attracts platelets, the elements of the blood that cause a clot. And it causes a clot, blocking off flow in the artery. Now, you don't need a 90 percent narrowing in the artery for the lesion to break. It can be a much less narrowed artery that can be involved in a heart attack. So that's--plaque rupture is a very common problem.

And the other problem that can happen, particularly in women, is spasm. The artery is made up of muscle, the wall of the artery, and sometimes that can go into spasm, and it will block off the artery temporarily. And then if it blocks it off long enough a clot can form and then decrease blood flow because of the clot. So there are a few different mechanisms.

ANDREW SCHORR:

Right.

DR. MENDELSON:

Not every sudden death is because of coronary artery disease. Certainly, somebody could have had a silent heart attack and have a scar on the heart. That

could cause some electrical instability of the heart and arrhythmia, and someone can die suddenly from that. So there's lots of ways.

ANDREW SCHORR:

And, of course, stroke limiting blood flow and oxygen to the brain.

DR. MENDELSON:

Right. Stroke is a similar mechanism and certainly as devastating. So there's lots of different presentations.

Now, not every symptom from the heart is crushing, elephant sitting on my chest chest pain. There can be much more subtle symptoms. Women tend to have somewhat more subtle symptoms but they have to be paid attention. If a woman has risk factors for coronary disease, particularly if she's a diabetic because diabetics don't get classic symptoms, she's having some nausea every time she's walking up the stairs, that could be her heart. If a woman is running on a treadmill and develops jaw pain, that could be her heart. So it could be a little bit different but it's still could be from the heart.

Because what happens is all those nerves that receive signals from that area all feed into the spinal cord at the same place, and the brain can't always dissect where exactly the pain is coming from. So people have to be alerted that it's not always like we see on TV. It may be much more subtle.

ANDREW SCHORR:

But, Dr. Mendelson, women--in a family anyway or even if you don't have a family but you have friends--it's often the woman who is a caregiver, cares about other people, worries about other people, often puts themselves second. And then you have these subtle symptoms and Yeah, I'm a diabetic or Yeah, I know I have high risk factors, but you also don't want to face up to it. And that time lost could be critical. So I want to give you a little soap box for should women be hesitant to make a call, whether it's 911 or go to the emergency room or call their doctor. What do you want them to do?

DR. MENDELSON:

I want them to call 911 or go to the emergency room. If they're having a symptom that we described, something on that order. Because we have data that show that women do present later. And all of our things in cardiology where we go in and we open up the arteries and stop the course of a heart attack, that's all best done early. And if a woman stays at home, say she's having chest pain and she pops the Tums and she goes to sleep and wakes up and she's still having pain and she thinks

about something else, she's losing precious time and precious heart muscle. Whereas we know that women--any man gets a pain between his jaw and his bellybutton, she--oh, his wife is driving him to the hospital right away.

Treatments Options

ANDREW SCHORR:

That's right. That's right.

Now let's talk about treatments. You have everything from on one end heart transplant to the other end you have various drugs and things to open up the arteries. You can do it without major surgery. You have all sorts of medications. As a cardiologist, if a woman who has some risk or some disease, signs of disease if they get connected with the right provider with your range of treatments today, how well do you think it can be managed?

DR. MENDELSON:

Oh, very well. We have all sorts of things available to us. Besides lifestyle modifications we have great medications. We have once-a-day medications so it's not a matter of forgetting. We have medications that treat multiple things, that treat blood pressure, cholesterol, protect against heart disease. So there--it's really become much easier to treat medically because we treat more than one thing at a time. So we have a lot of options. But if people don't come to medical attention they cannot avail themselves of these opportunities.

ANDREW SCHORR:

Okay. So there you are. You're the director of the Center for Women's Cardiovascular Health there at the Bluhm Cardiovascular Institute. You all specialize in this. So help us understand the kind of services you have that are dedicated to women that--should they have concerns about their heart, they need help with a prevention program, they're at higher risk, they have heart problems, what are the ways you work to help?

DR. MENDELSON:

We are standardizing the care for women and the diagnosis and identification of risk factors for coronary disease. We are going to be offering an evaluation service and to help women identify their risk factors in a medical setting. We are going to educate women of the community. We are going to educate caregivers, health professionals, to help them alert women to their risk factors.

I do a lot of teaching, professional education, of my colleagues and I will talk to anybody who cares for women, ophthalmologists, obstetrics, obstetricians, gynecologists, anyplace where a woman interacts. Because it's important to help her identify what may put her at risk and get things treated.

ANDREW SCHORR:

So is the story here that there are things to pay attention to that are relative to the heart, whether lifestyle issues or medical issues, for women that we need to see a little differently rather than a one-size-fits-all for all human beings?

DR. MENDELSON:

Oh, absolutely. I think all the tests that have been designed have been designed for that 70 kilogram male. It's the paradigm, what you're taught in medical school. Some of the machines that we take picture of the heart become a little more problematic in women. Medications may be different. We have far to go as far as research, as far as looking at gender differences in medications that we use to treat coronary and heart-related problems.

We have a long way to go and that's part of our mission with our center is to do gender-based research to try and find out what's the best way of treating women.

Closing Comments

ANDREW SCHORR:

But the fact that heart disease is the number one killer of women, there must be some real urgency and real mission in what you all are doing.

DR. MENDELSON:

Absolutely. We've been doing this for a long time and now we have the opportunity to pull it together formally and to strengthen our message.

ANDREW SCHORR:

Well, it sounds like, for our listeners, whether you are a patient for the Center or not, that you have a wonderful resource there. People might want to pay you a visit sometime, Dr. Mendelson, or one of your colleagues. Because if you're concerned about heart disease, you're struggling with your weight, there's diabetes, there are risks in your family, it seems wise, I always believe, to connect with a specialist. And now that you have specialists particularly in women and heart disease, if I were a woman that would be a choice for me.

DR. MENDELSON:

We also want everybody on campus to be a specialist in women and heart disease, to be able to recognize there's a problem.

ANDREW SCHORR:

Right. I know you're a big internal advocate there, and that's important. And that's all really a part of the team. So if a woman has diabetes, she's seeing a diabetes specialist, you and that diabetes specialist have had some dialogue about her heart.

DR. MENDELSON:

Correct.

ANDREW SCHORR:

Makes perfect sense. Have the bright people working together with us as a partner.

And that's probably my last point I want to make. No matter what you do, unless the woman internalizes this herself you can't really make much progress, can you?

DR. MENDELSON:

Correct. Women have to show up. They have to show up for treatment. They have to show up to follow blood pressure.

There's an interesting situation. A woman who has high blood pressure during pregnancy will probably have high blood pressure later in life. But you can't disappear for 18 years or 20 years or 35 years from medical attention. She needs to have her blood pressure checked, because at some point her blood pressure may go up and needs to be addressed.

And what happens with blood pressure, if we're using that example, is that blood pressure is a silent killer. It moves on and destroys organs, specifically the heart, the kidneys and the brain, very quietly. And then all of a sudden there's a stroke or heart attack or kidney failure. So we need to--we could intervene very, very early in these patients. We just need to educate them and make it easy for them or acceptable for them and advantageous for them to seek medical attention early.

ANDREW SCHORR:

Well, I know what I'm going to do. I'm going to talk to my mother-in-law, I'm going to talk to my wife, I've got a daughter. I've got some work to do just as a loved one. And I think whether you're male or female, whether this applies directly to you or someone you care about, there's been some great information here.

Dr. Marla Mendelson, really wish you all the best in your work and the commitment you've made at your Center For Women's Cardiovascular Health at Northwestern Memorial Hospital in the Bluhm Cardiovascular Institute there. We wish you well.

If someone wants to see Dr. Mendelson or get connected with the Center, all the information is on website, nmh.org, and then you're just looking for the Center For Women's Cardiovascular Health and Dr. Marla Mendelson.

Dr. Mendelson, thanks for being with us on Patient Power.

DR. MENDELSON:

My pleasure. Thank you so much.

ANDREW SCHORR:

Yes ma'am. And this is all a service of HealthNet and Northwestern Memorial Hospital. I'm Andrew Schorr from Patient Power. We wish you and your family the best of health. And remember, as you heard here, knowledge can be the best medicine of all.

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