

SLEEPING THROUGH THE DANGER

For most people, the hours just after rising, from 6 a.m. to noon, are the most likely times for heart attacks, while the sleeping hours are the safest.

But for the millions of people who have obstructive sleep apnea, a breathing disorder, heart attacks are much more likely in the sleeping hours, a new study finds.

Researchers from the Mayo Clinic say that for reasons that are unclear, people with the disorder are much more likely to have heart attacks from 10 p.m. to 6 a.m.

The study, which appeared last week in *The New England Journal of Medicine*, was led by Dr. Apoor S. Gami.

For people who have sleep apnea, the likelihood of heart attacks' occurring in the sleeping hours makes sense, given the tremendous stresses the disorder places on the body, said Dr. Virend K. Somers, a co-author of the study.

People with sleep apnea may be wrenched awake hundreds of times a night - often without their knowledge - when their airways collapse and they stop breathing.

Although the disorder has not been proved to increase the risk of heart attacks, it is suspected of doing so,

and it has been linked to high blood pressure.

Dr. Somers said he believed that effective treatment for sleep apnea would reduce that patient's risk for a heart attack.

The problem, he said, is that so many people do not realize they have the disorder. (Snoring is often a symptom.)

"The vast majority of sleep apnics are still not diagnosed or treated," he said.



WOMEN ARE SAID TO FACE HIDDEN HEART DISEASE RISK

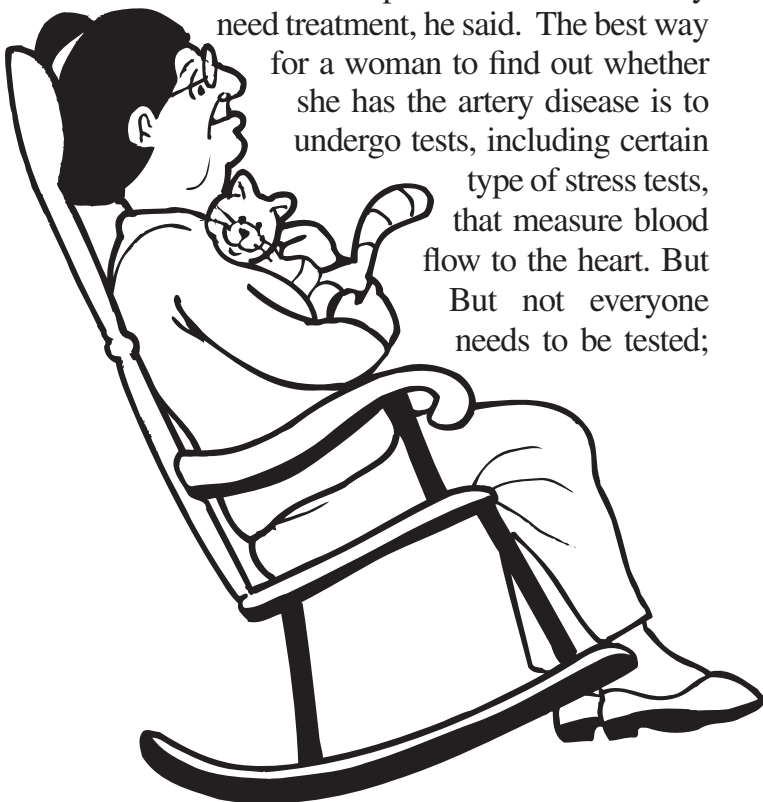
Women are more likely than men to have a hidden type of coronary heart disease in which their heart muscle is starved for oxygen even though their coronary arteries look clear and free of blockages on X-rays, doctors are reporting.

The condition, which may affect three million American women, greatly increases the risk of a heart attack. Its main symptom is chest pain or discomfort. In many women, the pain occurs but nothing shows up on an angiogram, a test in which dye is injected into the coronary arteries and they are X-rayed in a search for blockages, so doctors conclude that no treatment is needed.

But patients may then go on to have heart attacks or develop heart failure, a weakening of the heart muscle that can be debilitating and ultimately fatal.

“When there are no blockages, everybody slacks off, including the patient and we don’t want to do that,” said Dr. George Sopko of the National Heart, Lung and Blood Institute. Such patients almost certainly need treatment, he said. The best way

for a woman to find out whether she has the artery disease is to undergo tests, including certain type of stress tests, that measure blood flow to the heart. But But not everyone needs to be tested;



women with symptoms, a family history of heart disease or severe risk factors may be candidates.

The findings are among those in a series of articles to be published today in two medical journals — the Journal of the American College of Cardiology, and Circulation — exploring the differences in heart disease between men and women. The subject has drawn increasing interest in recent decades, as scientists began to realize that the results of previous studies, done mostly in men, did not always apply to women.

Among the differences already known are that women with heart disease tend to be sicker than men by the time it is diagnosed, to benefit less from bypass surgery and to have more severe symptoms when they develop heart failure. Some of the difference is because women are older and frailer when they develop heart disease, but that does not account for all of it.

Symptoms of heart attack also tend to differ. Men report crushing pain in the chest, while women are more likely to feel dizzy, sick, short of breath and sweaty.

Heart disease, strokes and other cardiovascular diseases are the leading causes of death in the United States and other developed countries. They killed 910,600 people in the United States in 2003, the most recent year for which data are available; more than half the deaths, 484,000, were among women.

Although women’s risk is greatest after menopause and increases with age, heart disease is the No. 1 cause of death in all women older than 25. Overall death rates from coronary disease have declined in the past few decades, but most of the improvements have been in men’s rates.

The cause of the hidden disease being described today is a diffuse buildup of fatty deposits inside the walls of the coronary arteries and in the very small arteries in the heart. The deposits, or plaques, do not show up as blockages on X-rays, but they still interfere with blood flow and can damage the heart muscle, causing ischemic heart disease. (“Ischemia” means “inadequate blood flow.”)

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But often the condition is not recognized, and the women are told they have nothing to worry about. Instead, Dr. Sopko said, they should be treated aggressively for other problems that lead to artery disease like high cholesterol, high blood pressure and diabetes. If necessary, he added, they should also be advised to quit smoking, lose weight and exercise more.

The researchers report that compared to a nonsmoker, a woman who smokes has a risk of dying from heart disease equal to the risk she would have if she weighed 90 pounds more than the nonsmoker.

“To women as patients, the message is, look, if you have symptoms, don’t think because you are a woman you are immune to having a heart problem,” Dr. Sopko said.

The findings are based on a government-sponsored study called Wise, for Women’s Ischemia Syndrome Evaluation. Begun in 1996, it included 936 women who had symptoms that led doctors to order angiograms. The women’s average age was about 58, but a quarter were young enough to be premenopausal.

Despite their symptoms, only a third of the group had obvious blockages in their coronary arteries. In a similar group of men, three-quarters or more would have a severe blockage, said Dr. Carl J. Pepine, the chief of cardiovascular medicine at the University of Florida in Gainesville and one of the lead investigators in the Wise study.

In the remaining two-thirds of the women — that is, those without blockages — more than half had abnormalities in their arteries, like an inability to dilate when needed, that could cause ischemia, Dr. Pepine said. The abnormalities occurred in both the coronary arteries and smaller ones that feed the heart, a network of tiny vessels called the microvasculature.

Tests showed that the artery walls were full of plaque but had grown outward to accommodate it, so that the opening appeared normal. But, eventually, the condition may progress enough to start pinching the artery shut, Dr. Pepine said.

After four years, the rate of deaths or heart attacks

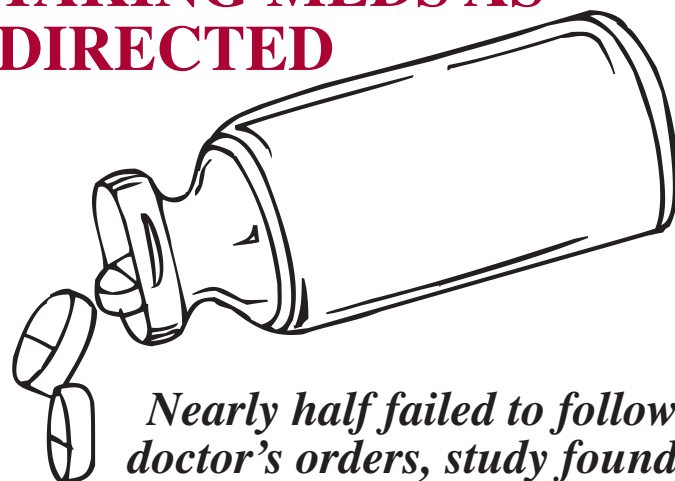
in the group without blockages was 10 percent.

“That’s much too high for somebody with a normal coronary angiogram,” Dr. Pepine said.

It is not clear why women seem more prone to the hidden vascular disease, the researchers said, though it may be linked to hormonal imbalances and a greater tendency to suffer from inflammation, which plays a role in artery disease.

New York Times

HEART PATIENTS NOT TAKING MEDS AS DIRECTED



Nearly half failed to follow doctor’s orders, study found

A lot of people with heart disease aren’t taking the medications their doctors prescribe for them as often as they should, cardiologists report.

Almost half of the 31,750 people treated at Duke University for major heart problems in a seven-year study acknowledged that they were not taking beta blocker drugs, aspirin and cholesterol-lowering drugs exactly as their doctors had ordered, according to a report in the Jan. 10 issue of *Circulation*.

In fact, the study showed, the patients who would benefit most from drug therapy -- the elderly, those with heart failure, those with other diseases -- were the least likely to be using them as directed.

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The study participants had all undergone at least one heart procedure, such as bypass surgery, or had at least 50 percent blockage of one coronary artery. Yet, while a majority did take the drugs now and then, many did not take them regularly.

For aspirin, presumably the easiest drug to take, 29 percent said they did not consistently use it as ordered. The compliance rate was much lower for other medications: 46 percent said they took beta blockers as ordered, and only 44 percent followed instructions for using lipid-lowering drugs such as statins.

The usage of ACE inhibitor drugs by people with heart failure, the progressive loss of ability to pump blood, were even lower: only 20 percent said they took the medication consistently.

“My feeling is that a number of factors are responsible,” said study author Dr. Kristin Newby, an associate professor of medicine at Duke. “Cost does play a role in it, but health-care providers are the key part of the issue. That includes physicians, nurses and pharmacists.”

Patients sometimes don’t realize the importance of taking the drugs, Newby said. While the study was not designed to show the repercussions of not taking drugs as ordered, there were indications that patients who followed instructions on drug therapy had a better survival rate.

“This is consistent with the results we see in randomized trials,” she said.

It will take a concerted effort on the part of doctors and other medical professionals to correct the problem, Newby said.

“We have to develop algorithms for checking on medication use,” she said. “It means checking every time they come in for a visit, and helping patients and their families understand the importance of taking medicine. It requires doing a lot of little things.”

“There were suspicions about inconsistent use of

heart drugs,” Newby said, “but it’s always a surprise when you see numbers like these. The magnitude of the problem is certainly eye-opening, and it should be a wake-up call for us.”

There has been some progress toward improving compliance, noted Dr. Sidney Smith, a professor of medicine at the University of North Carolina, but his accompanying editorial in the journal said, “We have miles to go before we sleep.”

“We can’t afford or justify neglect of this issue,” added Smith, a spokesman for the American Heart Association. “We need a major focus in our health-care system to recognize and solve this problem.”

HealthDay

LIVING WITH COPD

Chronic obstructive pulmonary disease (COPD) can be managed, although it cannot be cured at this time. Management includes quitting smoking if you smoke, taking steps to avoid shortness of breath, and staying active and eating well. Also, learning about COPD and support from your family and friends will help you cope with COPD.

Quitting smoking is the most important step you can take to prevent or slow damage to your lungs—it is never too late to stop smoking. No matter how long you have had COPD or how serious it is, quitting smoking will help slow the disease and improve your quality of life.

Avoid shortness of breath

Do all you can to make breathing easier. This includes:

- Avoiding conditions that may irritate your lungs, such as indoor and outdoor air pollution; smog; cold, dry air; hot, humid air; or high altitudes.
- Taking rest breaks. Schedule short rest breaks when doing household chores and other activities. An occupational or physical therapist can

help you find ways to do everyday activities with less effort.

- Staying as active as possible and getting regular exercise. Try to do activities and exercises that build muscle strength and help your cardiovascular system.
- Learning breath training techniques to improve airflow in and out of your lungs.
- Discussing pulmonary rehabilitation with your health professional.
- Taking the medications prescribed by your health professional. If you use a metered-dose inhaler (MDI) or nebulizer, be certain you know how to use it properly.

Eat well

Good nutrition is important to maintain your strength and health. Problems with muscle weakness and weight loss are common in people with COPD. People with COPD who are very underweight, especially those with emphysema, are at higher risk of death than are people with COPD who have a normal weight.

Seek education and support

Treating more than the disease and its symptoms is vital to success. You also need:

- Education. Educating yourself and your family about COPD and your treatment program helps you and your family cope with your lung disease.
- Counseling and support. Shortness of breath may reduce your activity level and make you feel socially isolated because you cannot enjoy activities with your family and friends. You should be able to lead a full life and be sexually active. Counseling and support groups can help you learn to live with COPD.

- A support network of family, friends, and health professionals. Learning that you have a disease that may shorten your life may trigger depression or grieving. Anxiety can make respiratory symptoms worse and can trigger or prolong exacerbations. Support from family and friends can reduce anxiety and stress and make it easier to live with COPD.
- To stick with your treatment plan. Following a treatment plan will make you feel better and less likely to become depressed. A self-reward system, such as a night out to eat after sticking to your medication and exercise schedule for a week, can help keep you motivated.

HealthWise

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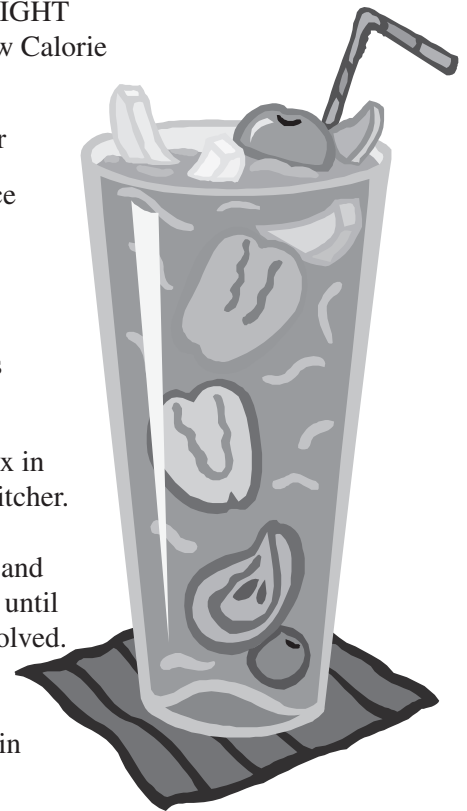
tub CRYSTAL LIGHT
Peach Flavor Low Calorie
Iced Tea Mix

- 5 cups cold water
- 1 cup orange juice
- 2 peaches, sliced
- 1 cup raspberries
- 1 cup blueberries

PLACE drink mix in
plastic or glass pitcher.

ADD cold water and
orange juice; stir until
drink mix is dissolved.
Stir in fruit.

SERVE over ice in
tall glasses.



The goal of *LINCARE News* is to share timely information with clients of *LINCARE*. The contents are selected to provide guidelines for approaching the resolution of problems, but are not intended to provide medical advice for individual problems. The latter should be obtained from your physician.

Courtney Swift, Editor

OLDER SMOKERS MORE LIKELY TO QUIT FOR GOOD

Smoking may have less of a grip on older people than on the young, a new study suggests.

A Duke University study of 573 elderly smokers tracked health information from 1986 to 1996 and found that, of those who quit smoking during the first three years of the study, the majority remained quitters until they died or until the end of the study period.

Just 16 percent of the elderly quitters returned to smoking, the study found. This contrasts with previous research findings that young smokers who quit have a 35 percent to 45 percent rate of smoking relapse within two years of quitting.

“The patterns of smoking cessation in older people are quite different than previous research has shown with regard to smoking cessation in younger populations,” researcher Dr. Heather Whitson, a geriatrics fellow at Duke’s Center for the Study of Aging, said in a prepared statement. “More research is needed, but with greater understanding of motivations for quitting in later life, better cessation programs could be developed for this population. This would be particularly true if we could determine quality of life benefits and longevity for older

people who quit.”

This low smoking relapse rate among elderly people could be due, in part, to higher death rates in that group, the Duke team acknowledged. However, they said it may also reflect fundamental differences in habits and attitudes between older and younger smokers.

“Something novel may be motivating those older people who do give up smoking -- either they are really motivated to give up the habit or factors outside of their control are influencing the decision to quit,” Whitson said.

Loss of transportation (resulting in loss of access to cigarettes), onset of dementia, financial constraints, or a move to assisted living or a relative’s home where smoking is forbidden are among the other factors that may influence quitting among elderly smokers.

The study also found that older women may be more successful than older men at quitting smoking and avoiding relapse, and that both older men and women are more likely to quit if they’ve recently been diagnosed with a serious illness such as cancer or heart disease.