

Women's health comes of age

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s baby-boomers move into middle age, promoting and maintaining the health of older women has become a medical, social and economic priority. Although women live longer on average than men, many do so with chronic diseases. "Women get sicker; men die quicker," as the adage goes. Demographic changes together with the recent focus, especially in the industrialized world, on women's health have attracted unprecedented attention and brought new respectability and weight to the field of women's health.¹

Despite misconceptions to the contrary, most middle-aged and older Canadian women continue to die of cardiovascular diseases. Many women are unaware that cardiovascular diseases are 8 times more likely to kill them than much-feared and much-publicized breast cancer. Moreover, lung cancer has recently surpassed breast cancer as the leading cause of death due to cancer in women; this is entirely the result of increased rates of smoking among women. Although breast cancer remains a leading health concern among women, the good news is that recent data show that mortality rates for breast cancer are finally beginning to decline.

The bad news is that more and more teenage girls are starting to smoke and that lung cancer incidence among adult women continues to escalate. The irony of this tragedy became clear to me recently when a cigarette-smoking woman requested my help in campaigning against environmental pollution, which she viewed as an important cause of breast cancer. In reality, the causes of breast cancer (and, indeed, of most cancers) remain elusive. In the meantime, we need to use the vital information we *do* have to best effect. At the end of 1997 we continue to await more effective antitobacco legislation from the minister of health, while the tobacco lobby continues its iniquitous practices unabashed.

Several studies have confirmed that some life-threatening conditions such as heart disease and lung cancer are diagnosed later in women than in men, and that women have less access than men to specialized medical services such as renal transplantation, cardiac angiography and coronary artery bypass surgery. These findings, along with increased mortality rates in women after a first my-

ocardial infarction, percutaneous transluminal coronary angioplasty and coronary artery bypass surgery (which vary by jurisdiction but in some studies have been shown to be twice as high in women as in men) have stimulated an increased interest in health services research. When the lack of cardiac procedures is compared to the high hysterectomy rates (which also vary greatly within and between provinces), one wonders why some medical problems in women get too little medical attention while others get too much. Gender and small-area variations in utilization cry out for lay and professional education, the establishment of more women-friendly services and the development of clinical practice guidelines.

1997 was another bumper year for developments in genetic research. The Human Genome Project, now well ahead of schedule, offers exciting new insights into the pathogenesis of a variety of diseases and conditions. One of the most pressing questions this progress raises is not whether we *can* test for defective genes but whether we *should*.² The announcement this fall of a pre-implantation genetic diagnostic service in Toronto related to in-vitro fertilization is a case in point. Although the prevention of



serious genetic diseases is a worthy goal, what about risk identification for adult-onset disorders for which there are as yet no effective treatments? To date, genetic testing has focused predominantly on women through prenatal tests and through testing for genetic predisposition to breast and ovarian cancer. This gender difference is likely to decrease as scientific advances permit the detection of genetic disorders that affect both sexes equally. However, the impact of genetic testing on privacy, confidentiality, insurability, marriageability and employment need urgent and thoughtful study. Policy development is essential to guide the scientific and ethical course of research and clinical practice in the genetic arena.

In today's society disproportionately more older women than men are afflicted by Alzheimer's disease, osteoporosis and arthritis. The effects of these disorders on independent living, quality of life, mobility and morbidity make them important concerns in women's health. The increased use of estrogen and bisphosphonates and the development of the soon-to-be-released selective estrogen receptor modulators (SERMs) offer the promise of new preventive and therapeutic strategies for osteoporosis and perhaps other diseases in middle-aged and older women. However, in rushing to embrace pharmaceutical solutions, we must not forget the crucial role of diet, exercise, smoking avoidance and the prevention of falls in maintaining the health of older women.³

The "decade of the brain" has brought new insights into the neurochemical complexities of central nervous system functioning. Elucidating the role of serotonin in controlling mood, anxiety, sexuality and appetite offers powerful new therapeutic tools for treating predominantly female conditions such as anxiety, depression and eating disorders. Toward the close of this year, however, the much-touted appetite suppressant combination drug, fen-phen (fenfluramine and phentermine), was withdrawn from North American markets when it was found to cause both pulmonary hypertension and heart valve malfunction. Women were its primary users and will ultimately be the greatest losers when the drug's adverse results are tallied.

Health care restructuring across the country offers new challenges in women's health. Ambulatory surgeries, early discharge programs and community care may send ill women back to unsupportive environments, thereby delaying recovery. In addition, the need to care for ill partners or sick children at home may be overwhelming for already time-taxed working women. It has not escaped notice that women are disproportionately affected by ambulatory or short-stay procedures (delivery, abortions, dilatation and curettage, breast biopsies and partial mastectomies), by job losses resulting from health care restructuring (nurses, dietitians, occupational therapists,

social workers and cleaners) and by pay inequities in the health care sector.

It is more important than ever to adopt an approach that takes into account the social determinants of women's health, the contextual effects of violence, poverty and discrimination, and the role of education, opportunities, housing, reproductive choice and emotional well-being. One encouraging fact is that Canadian women now live longer than ever before. The challenge for the millennium will be to keep them healthy while they do!

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