

The heart attack that doesn't look like one

There's a common misunderstanding that breast cancer is the biggest threat to women's health and lifespan. The reality is that coronary heart disease kills more than twice as many Australian women as breast cancer, and around 20 women die of it every day. Heart disease is still thought of as a male problem, and as a result women can experience delays in getting lifesaving treatment.
Sometimes that's because women don't recognise the symptoms, and sometimes it's because health professionals miss them.

The other important factor is that the classic symptoms of a heart attack, like central chest pain going down the left arm, are more typical of men than women. While women do experience a heart attack in this way, the symptoms are often more subtle yet just as important to identify.

Here are some of the patterns which, if they last for 10 minutes, indicate the need to call 000 and get to hospital as quickly as possible. Chest pain is the most common heart attack symptom in women, as it is in men, but women are more likely than men to experience:

- Pain in the back, shoulders, arms or jaw
- Shortness of breath
- Dizziness
- Indigestion
- Sweating
- Nausea or vomiting

Research has found that even when women recognise they're having a heart attack, they delay calling for an ambulance because they want to sort things out at home beforehand.

The message is act quickly. There's no time to be lost, and it needs to be an ambulance rather than a car. That's about being able to receive lifesaving assistance in transit, and the speed of getting into the ward on arrival.

The Heart Foundation has more information for women and professionals.

References

Heart Foundation. Women and heart disease for professionals. https://www.heartfoundation.org.au/for-professionals/women-and-heart-disease-for-professionals

Obesity gets a definition that isn't BMI

It's long been known that Body Mass Index is far from perfect when measuring overweight and obesity. People who are very muscular can have a high weight relative to their height but not carry much fat. BMI also doesn't account for where the fat might be, and fat in the abdomen, visceral fat, is the fat that's really toxic for health. That's why alternate measures such as waist circumference, waist to hip ratio and waist to height ratio have been developed. And then there's what the obesity might be doing to someone's health. Some people are surprisingly healthy despite a high BMI and need a different approach from their doctor than someone who's being made sick by their obesity.

So for all these reasons, an international group of experts has redefined obesity in relation to whether there are complications and signs of organ damage such as diabetes, heart disease, liver disease, some cancers, mental health issues or trouble with activities of daily living. They called this clinical obesity. People without these side effects of obesity should now be defined as having preclinical obesity, in other words they may be at future risk.

A new study has looked at what difference the new definition makes to assumptions about how much obesity is out there. Levels of clinical obesity in children are much lower than the obesity rate when measured by BMI alone. In mid-life clinical obesity is commoner in men than women, and in later life it is more common in women. The main point is that the harm done by obesity accumulates with age, and the younger it is tackled the better. In mid to late life it's important to know whether obesity is causing organ damage so it can be treated more comprehensively.

Healthy measures of body size and fat

- BMI between 18.5 and 24.9, with a lower upper cut-off for people of South Asian or First Nations ancestry
- Waist circumference of 94cm or less in men and 80cm or less in women, again lower in some ethnic groups
- Waist to height ratio below 0.5, the measure gaining ground because it applies regardless of gender or ethnicity

If waist to height ratio is above 0.5, experts argue the person should be investigated for metabolic dysfunction associated fatty liver disease (MAFLD). More on MAFLD from the RACGP.

References

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**Dr Norman Swan AM and Dr John Aloizos AM*

Speed counts when you're counting your steps

The 10,000 steps a day figure has been quietly losing ground for years. It traces to a 1965 Japanese pedometer called the Manpo-kei, whose name translates as ten thousand steps meter, rather than to any trial, and the accumulated cohort evidence has consistently put the point of diminishing returns well below it. What has changed more recently is the second variable. Wrist accelerometers can now measure not just how many steps someone takes but how quickly they take them, and cadence is turning out to carry information that volume alone does not.

Step count is unusual in that it is the one activity measure people arrive already tracking. It sits on a watch or a phone and it is the number they quote. The difficulty is the target attached to it. For someone deconditioned, in their late seventies, or managing heart failure or osteoarthritis, 10,000 is not an aspiration so much as a number that ends the conversation rather than starting one. A step counter also treats a slow shuffle around a supermarket exactly the same as a brisk walk to the station.

Separating the two variables gives a more workable conversation. Volume is how much, intensity is how fast, and they are not interchangeable. Framed that way, someone who cannot add distance still has somewhere to go, which is the same walk taken faster. That is a considerably easier ask than doubling a step count, and it lands differently with people who have already decided they are not a 10,000 steps person.

A University of Sydney-led analysis published in Medicine and Science in Sports and Exercise examined this across 65,253 UK Biobank participants with a mean age of 61.5, who wore wrist accelerometers and were followed for a median of eight years. The models adjusted for daily step count, so what they isolate is the contribution of pace independent of how far someone walks. Peak cadence measured across any window from one minute to a full hour was associated with lower all-cause and cardiovascular mortality, with hazard ratios for all-cause mortality falling between 0.65 and 0.74 at median levels, and the various measures proved largely interchangeable. The exception is the instructive part. Purposeful cadence, which counts only the steps taken during minutes of genuine walking and then spreads them across the whole day the monitor was worn, showed no association at all. Pace appears to carry information when it is measured at someone's fastest sustained effort, and to disappear when it is diluted across the rest of the day.

The practical translation is a number most people can act on. Validated cadence work puts moderate intensity at around 100 steps per minute for adults, which is roughly 3,000 steps across a 30 minute walk, and it is fast enough that talking is possible but singing is not. For someone already logging 4,000 unhurried steps, half an hour at that pace is a more realistic and better evidenced target than another 6,000 steps at the same speed. It also gives the number on their wrist a second dimension, which is useful for anyone who has plateaued and concluded that walking has stopped working for them.

References

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2. Tudor-Locke C, et al. Walking cadence (steps/min) and intensity in 61-85-year-old adults: the CADENCE-Adults study. Int J Behav Nutr Phys Act. 2021.

Dr Norman Swan AM and Dr John Aloizos AM