# Claire Mounier-Vehier – Cardiologist, Head of Vascular Medicine & Hypertension, Heart & Lung Institute of the University Hospital of Lille, Honorary President of the French Federation of Cardiology



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*Speaking exclusively to PharmaBoardroom at the International Women's Day 2020 event at the Franco-British Chamber of Commerce in Paris, esteemed cardiologist Professor*

*Claire Mounier-Vehier outlines why cardiovascular disease is not simply a masculine issue, the cardio problems particularly affecting women, and why better communication and prevention is vital to countering what she sees as a ticking epidemiological time-bomb.*

**You are one of the few female professors of cardiology in Europe, working at one of the leading hospital services in Lille, Northern France. How did you come to that specialty?**

I was actually initially attracted to the gynaecology specialty. But unfortunately, to study gynaecology, you had to be able to conduct surgery, something I could not do as I suffer from a condition called amblyopia, a visual impairment. Cardiology was next on my list, that's why I picked it.

As a young intern, I had the chance to work with Professor Carre, who was at the time one of the only professors who valued working with women. He is the one who coached me during my hospital internship (as part of my medical school degree). He was an early leader in paying interest to women with hypertension. This is how my interest in female cardiology started.

In France, unfortunately, there are far more women who pass the first part of their medical study pathway, but then drop out when the hospital internship phase of studies starts. If you look past that, for those aspiring to embrace a university career, you have two major challenges; one is cultural with a male-only culture, and the second one is related to personal reasons. Many women drop out because they realize the amount of work and personal involvement they need to put in to succeed, for very little financial reward. This is often paired with maternity and family building, and as a result, many female candidates decide to drop out halfway.

We have very few female university doctors, either through lack of opportunity or for personal choices. I am the co-founder of a brand-new organization that is focusing on this issue and finding solutions to better motivate and accompany women in this pathway. At the end of the day, it is only an organizational problem. I had three daughters and they never complained about my career!

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**What triggered your interest in the cardiovascular problems that particularly affect women and becoming so vocal about the issue?**

It has been a slow process. I was always naturally versed in the prevention of hypertension. I witnessed the impact of pregnancy and contraception on hypertension and as I got older I paid more attention to the link between menopause and hypertension. We initially developed a European Research Centre in Lille.

As we were publishing scientific papers on the topic, we realized that there was an out of control progression of cardiovascular diseases affecting women, especially with heart failure of women below 50. We started to be increasingly confronted with the appearance of heart failures or

diseases such as coronary arteritis in young women that I had never witnessed as a younger doctor.

Nowadays there are young women ending up in emergency units for heart failure issues. Over the last 25 years, the development of these diseases has been so fast and the problem has become so acute, that as one of the specialists in the area, I started to get increasing demand for speeches and conferences on the topic. The more I spoke, the more interested I became.

I would like also to highlight the influence of my own gynaecologist, Doctor Brigitte Letombe who was also extremely engaged.

We decided that it was important to collaborate, so we established a gynaecology/cardiology healthcare pathway. This is something that organizations like the American Heart Association were also advocating for.

**You use very strong language such as ‘epidemic’ and ‘societal urgency’ to talk about women’s cardio health. How deep is the problem?**

The first thing to understand is that it will not get better, as this is very closely linked to environmental issues.

Traditionally, people believe breast cancer is the biggest killer for women. I hate to make comparisons as unfortunately an increasing number of women are affected by both. But for the sake of scale, the ratio of death between death by breast cancer and by coronary artery disease is one for seven. This means that for every woman that dies of breast cancer, there are seven who die from heart failure.

This ratio is largely underestimated, as it only includes death by coronary disease. In reality, if you include strokes and other cardio-related diseases, the ratio is one in 16. Women die 16 times more of cardiovascular diseases than of breast cancer. The reason for this is extremely simple; it’s called prevention and diagnosis.

We have just launched a program with the French Health Ministry, in the Hauts de France Region, to include regular diagnostics of cardiovascular diseases, and a risk factor questionnaire for all women of 50 and over, the same way it is done for breast cancer. If the experiment is conclusive, we hope to extend this to the national level. This is nothing new, or ground-breaking, but these are proven methods and solutions.

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**How do you explain the fact that cardiovascular drugs and treatments seem to work better for men, resulting in a lower death toll, than they do for women?**

Remember that treatments were developed mainly for men. Actually, for some reason and in many cases, unwanted side effects when using those drugs are much stronger with female patients than with men. For example, women taking statins have twice as much cramp as men. The doses themselves have been developed on/for men.

Women have a very different cardiovascular metabolism to men. Unfortunately, following past trials and through fears of potentially negative effects on potential babies, to be included in a clinical trial a woman needs to either have had the menopause or be taking a contraceptive treatment. This not only limits the number of potential candidates but also has an impact on our knowledge. There are of course trials on female animals, quite a few epidemiology studies, but not so many trials on drugs and treatments.

Having said that, following a large study on post-intensive cardiology care, we realized that beyond the problem of treatment and treatment dosage, there was also a serious discrepancy between treatments prescribed to women and men. Doctors have a tendency to treat women less than men, and in some cases completely forget to prescribe statins. In some cases, they only get half of what would be necessary in terms of treatment.

The biggest issue remains the lack of prevention and diagnostics. Women often contract the disease, after a first heart failure. We should be able to diagnose the symptoms and start treatments earlier and avoid this in many instances. This is at the core of what I preach.

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**Is this a French specific issue or a global trend?**

This is a global trend. The causes behind this “epidemic” are global: tobacco, alcohol, sedentary lifestyles, obesity… Let’s not forget stress, which is the second largest factor for coronary artery disease just after tobacco (it is only the third for men).

My message is very simple: listen to yourself, get tested, and pass the message to others. Doctors also have a responsibility; we need to change the common idea that cardiovascular diseases are masculine diseases. They are not, and the problem is acute with women. So, there is a need for better consideration.

30 years ago, the WHO pointed to AIDS as the biggest epidemiologic threat; 15 years ago, they highlighted cancer as the biggest issue. A few weeks ago, they raised the alert that cardiovascular diseases are the biggest threat to population health. It is essential that the public and health authorities understand that this is one of the biggest health challenges of our immediate and midterm future.

The good news is that in 80 percent of cases, these problems could be avoided with adequate prevention. I am a firm believer that with adequate prevention we could reverse the trend because, from a clinical point of view, treatments and technology exist. We need more prevention. In France, a patient who suffered after his first heart failure will cost the national health system up to EUR 600,000. We should be able to avoid this with better information, prevention and early diagnosis.

One of the issues we face in France is that prevention is often left aside. Many things were done for diabetes, but very few for cardiovascular diseases. There was never a true national plan in this area. There is very little funding dedicated to automatic diagnosis and testing.

I have had the chance to lead the French Federation of Cardiology for four years. It has been a great experience, which gave me the ability to expand my skills in people management, communication and marketing, recruitment, finances, accounting and transformation of a large organization. With that experience, my dream is to create a foundation dedicated to women’s cardiovascular disease. The time is nigh to drive changes for the benefit of all women in the world for all generations!

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