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Commentary: Coronary artery disease: Equality of care for women and men

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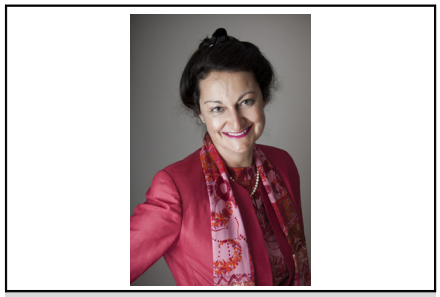

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CENTRAL MESSAGE

Women and men might be different physically but are equally vital in our social structure; they both deserve equal consideration and treatment specific to their needs.

Zwischenberger and colleagues,[1] in their Invited Expert Opinion on "Coronary Surgery in Women: How Can We Improve Outcomes", have addressed head-on deficiencies in the management of coronary artery disease (CAD) in women. The research done for this article is compelling. Understandably, there is frustration for all who treat women with coronary disease. Women are different from men and as a group have been documented to have fewer single/bilateral internal mammary and radial arterial grafts. However, because women present later in life with overt CAD, perhaps there is reluctance to use arterial grafting in older patients be they male or female. A study/review, that would compare rates of arterial grafting in men and women older than 70 years would perhaps unmask one reasonable difference of the arterial grafting rate of women versus men.

The "Algorithm of Use of Arterial Grafts in Women" is not necessary; this is an algorithm for both men and women who require coronary surgery. Except for reducing/ceasing hormonal replacement in postmenopausal women, the guidelines are the same. The truth might be that if an age modifier does not exist to explain fewer arterial grafts in women, lower thresholds may be present for excusing arterial grafting (ie, guidelines are less adhered-to in women). If so, the "mindset" toward CAD in women might need adjustment. But "mindsets" are not solely responsible: women have fragile tissues, coronary arteries are smaller, and because of delayed diagnosis, disease might be more advanced. In addition, women are ultimate givers, and may be so devoted to their loved ones as to present late, putting their own health at risk to continue serving their family.

Also, the diagnosis of CAD in women can be frustrating and difficult: Dr Gerald M. FitzGibbon of the "A,B,O graft patency classification" fame used to say: "The antechamber of hell is interpreting ECGs of women and hell itself is interpreting their stress EKGs." Presenting symptoms of women with CAD may be varied and may not follow the classical 'chest tightness, radiation to the left arm' symptom complex, contributing to delayed or inaccurate diagnosis of CAD.

The concept of "the innovative idea of surgeon and patient gender concordance" is disturbing. Suggesting a specialty of only women surgeons operating on women for coronary surgery is a slippery slope and tantamount to cobblers fixing only left-sided shoes. Although well-meaning, the overall tone that women might be better cared for by women physicians and surgeons suggests bias toward men. One must be careful to avoid the pendulum swing. Also playing this forward, how might women surgeons feel if men decide to have only men operating on men? Segregating the problem is not a solution. Instead, perhaps women could be given the choice of male or female surgeons.

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This is not to say that there exists no bias regarding fewer arterial grafts for women; bias is often unconscious and stems from generational beliefs of designated roles for men and women, passed on for centuries. Also, not all individuals are as open-minded to change as others.

Men and women might be different physically but are equally vital in our social structure; they deserve equal consideration and treatment specific to their needs. Acknowledging differences is only the first step; action must follow to augment care for women. The words, "woman" and "women" have the words "man" and "men" within them. Women and Men are like coins with 2 different sides—similar but "the sides" are different. Vive la difference!

Reference

1. Zwischenberger BA, Jawitz OK, Lawton JS. Coronary surgery in women: how can we improve outcomes. *J Thorac Cardiovasc Surg Tech*. 2021;10:122-8.