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Myocardial Infarction (MI) in Women
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Introduction
Cardiovascular disease (CAD) is the most common cause of death for men and women in the US. The disease has been extensively studied in males, although, the prevalence of CVD has prompted many studies for treatment and prevention in females. Despite this, women have been shown to have lower rates in mortality rates in women have surpassed that of men. Recent reports indicate that CVD killed more women in the US than men in their 40s and nearly as many men than women in their 50s and 60s. In the US, 42% of women died from heart disease (Sancho et al, 2011, p. 459; Gulati & Bailey Meir, 2012, p. 143).

Population and women with CVD is expected to rise by 1.5% annually, as more men and women seek treatment for ischemic pain and infarction (Sancho & del Carmen Solano, 2011, p. 146).

• More women have died from CVD and the probability of a woman having fatal CAD increases more than eight times. Women remain less aware of the signs and symptoms of the disease (Sjöstrand-Ström et al, 2011, p. 459).

Pathophysiology of MI

MI is associated with countless signs and symptoms (i.e.) and some specific characteristics that frequently exist.

C/o chest pains in a women can be a predictor adverse CVA event in the absence obstructive CAD. Women c/o chest pain at rest while at rest longer than usual. MI in women is preceded by signs of back pain, arm, shoulder, jaw, throat pain and toothache.

Hormonal changes experienced after menopause presents a critical role. Reduced estrogen levels cause rapid dysfunctions and significantly increases the incidence of MI (Edwards 2012, p. 576; Gulati & Bailey Meir, 2012, p. 142).

Unique Presentation in Women

• C/o chest pain in a women can best serve as a predictor adverse CVA event in the absence obstructive CAD.

The literature provides substantive insights into the pathophysiological differences that exist between men and women with myocardial infarction. It is now known from postmortem studies that women manifest coronary plaque erosion and dissection (Gulati & Bailey Meir, 2012). The evidence indicates the presence of a unique syndrome that is manifested in a different type of lesion. Women experience chest pain that persists longer than in men, and women have lower levels of cardiac enzymes. The disease process is less detectable in women, and they may not present with the classic symptoms of chest pain.

The relevance of the pathological process is of vital significance to health professionals in number of ways. First, the knowledge gleaned from the research must be utilized to achieve the primordial prevention of chest pain and disease prevention in area of myocardial infarction in women.

This requires initiating a robust health education and screening program and reducing the compromising modifiable factors (i.e., malnutrition, hypertension, and diabetes that remain very crucial to disease prevention and treatment. Women are more likely to be impacted from CVD, and increased awareness of the disease process must be achieved.

The research outcome demonstrate gender-specific and sex differences in other to eliminate the obstacles that have kept women from improved outcomes. The literature provides substantive insights into the pathophysiological differences that exist between men and women with myocardial infarction.