Your Heart in Midlife

Heart disease is the leading cause of death in women — and one of the most preventable. What is really happening, and how we protect it at Ovella.

01 Why heart disease is missed in women

THE GAP

Heart disease is too often found only after a heart attack or stroke because prevention and screening get so little focus in women.

- Cardiovascular disease has been the **#1 cause of death in women every year since 1984.**[1]
- Women are **more likely to die after a heart attack** than men — especially younger women — and less likely to get prompt, aggressive cardiac care.[2,3,4]
- Heart symptoms in women — nausea, indigestion, jaw or back pain, fatigue, breathlessness with or without chest pain — are often blamed on stress or anxiety.[5]
- **53% of women vs 37% of men** were told by a provider their symptoms were not heart-related.[5]

02 The menopause turning point

ESTROGEN

Before menopause, estrogen helps protect the heart. It supports:

- **Nitric oxide** — helping blood vessels relax and widen[6,7]
- A healthy vessel lining (the **endothelium**)[6,7]
- A favorable **cholesterol profile**[6,7]
- Better **insulin sensitivity**[6,7]

As estrogen falls, these protections fade — blood pressure, cholesterol, visceral (belly) fat and insulin resistance tend to rise. Women live longer than men, but often spend those extra years in worse health.

KEY FACT Midlife is the window where prevention has the most to offer.

Where hormone therapy fits — the honest version

HONEST CAVEAT Guidelines do not recommend HRT be started for the *sole purpose* of preventing heart disease. That guidance is largely based on the original Women's Health Initiative — oral conjugated estrogen (Premarin) + medroxyprogesterone (MPA) — where the small absolute increases in coronary heart disease events were primarily seen in women starting therapy **more than 20 years past menopause.** Started **younger** and with **transdermal, body-identical** formulations, the risk picture changes substantially — and there is a clear "window of opportunity" where HRT is most likely to be cardioprotective.[8,9,14]

03 Where hormone therapy fits

HRT

- **Timing matters — the "window of opportunity."** Starting estrogen within ~10 years of menopause (or before age 60) is linked to neutral-to-favorable cardiac effects and slower plaque progression; starting many years later, particularly with oral estrogen and synthetic hormones, may increase risk.[8,9]
- **Old studies, old formulas.** WHI used oral CEE + a synthetic progestin (MPA) in women on average 12+ years post-menopause — different from today's lower-dose, transdermal, body-identical options. WHI re-analyses by age and years since menopause support the timing hypothesis.[8]
- **Trials in younger women support cardioprotection.** DOPS (10-year RCT, oral estradiol + norethisterone in *recently* post-menopausal women) showed reduced mortality, heart failure and MI without increased breast cancer, stroke or VTE.[20] KEEPS and ELITE confirmed early initiation slowed atherosclerosis progression and improved CV markers.[9,21]
- **Early or premature menopause raises risk.** Menopause before 40 is linked to up to ~90% higher risk of a cardiac event before age 60.[10] HRT at least until the natural age of menopause (~51) helps offset it.[11,14]
- **Stopping carries its own risk.** Cardiac and stroke death risk rises in the first year after stopping, especially under 60 — so without a firm reason to stop, we often continue.[12,13]
- **Higher risk changes the route.** When clotting or cardiovascular risk is elevated, transdermal body-identical estradiol is preferred — little effect on clotting, unlike oral.[14,15]

Screening & lifestyle: what protects your heart

The actionable side — what we screen for, what helps most, and the mindset shift behind the work.

04 How we screen — before symptoms

SCREENING

We don't wait for a heart attack to look. For midlife women we recommend:

- **Lipoprotein(a)** — Lp(a) at least once in every adult — now a Class I recommendation in the 2026 national lipid guidelines.[16]
- **ApoB, a standard lipid panel, and hs-CRP**; homocysteine added when individual risk warrants.[16]
- **Coronary artery calcium (CAC) score** for selected patients — a quick CT that detects calcified plaque. Used in women over 40, individualized by family history, labs and risk factors (Lp(a), tobacco, alcohol, metabolic syndrome, high cholesterol).[17,18]

KEY FACT A CAC score of zero is reassuring but not a guarantee — it can't see early, non-calcified "soft" plaque, so it complements the full picture rather than replacing it.

05 What helps most

LIFESTYLE

- **Eat Mediterranean / DASH style** — fiber, plants, healthy fats and lean protein: the most evidence-backed way to eat for your heart.[19]
- **Move with purpose** — aerobic activity plus strength training at least twice a week protects the heart and builds metabolism-supporting muscle.
- **Don't chase thinness** — metabolic risk (high blood sugar, blood pressure, triglycerides) can exist at a "normal" weight, and losing muscle to be smaller can backfire.

KEY FACT We focus on strength and metabolic health — not the number on the scale.

The real goal in midlife — protect, don't panic

PREVENTION	SCREENING	STRENGTH	FUNCTION
over reaction	*before symptoms*	*over smallness*	*over fear*

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