ETHNICITY AND THE HEART

Ethnicity is a difficult concept because it is more than just race. It incorporates your ancestry, religion, nationality and geography. Beyond genetics, it looks at your attitude about health and illness, your lifestyle choices, your customs and culture. As travel around the world grows exponentially and inter-racial marriages become increasingly common, ethnicity is even harder to define. There is, however, still value in looking at ethnic origin and its impact on health.

Atlanta is home to many different ethnic groups. We have large European populations, African Americans, Hispanics, Chinese, Koreans, Russians, Ukrainians and South Asians. In each of these groups cardiovascular disease remains to #1 killer but the manifestations of the disease vary significantly. Risk factors for heart disease remain the same in all ethnic groups but the proportion and age of onset for any given risk factor differs tremendously.

In the Caucasian population smoking has always been a major risk factor. While smoking is on the decline we still have a long way to go. As Caucasians shifted their diet that was rich in cholesterol, we have seen an excess of carbohydrate intake leading to the development of obesity and subsequently diabetes. The need to reduce carbohydrates and increase exercise is the #1 priority in this population that suffers greatly from heart attacks and strokes.

Many of the South East Asian countries have diets that are rich in their use of sodium. As a result there is a higher chance of a Chinese or Korean patient to have a stroke related to high blood pressure rather than a heart attack. Similar findings are seen in African Americans who also have a higher incidence of hypertension and secondarily strokes.

South Asians (individuals whose ancestry comes from countries like India, Pakistan, Sri Lanka, Bangladesh Nepal and Burma) have a fivefold greater chance of developing diabetes prematurely and as a result have the highest incidence of heart attacks in the world. In general South Asians also have smaller body size and therefore respond less well to mechanical intervention such as a stents or bypass surgery.

Hispanics also tend to develop obesity and diabetes earlier but do not have the same accelerated rate of heart attacks that South Asians or even Caucasians do. The level of inflammation within the body may be a contributing factor and there are tests that help in evaluating these levels.

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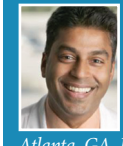
Visible minorities also tend to differ in socioeconomic status and this can impact access to health care. They often have a more fatalistic approach to life and are more inclined to use alternative medicines that include both homeopathic and naturopathic remedies. Language barriers, lack of cultually specific lifestyle advice and a variable social support network can all impact the development of heart and stroke disease. Our risk stratification tools such as the Framingham Risk Score have also been developed mainly for Caucasians and may underestimate true risk in other ethnic groups.

One of the biggest challenges to treating visible minorities is that much of our clinical research has focused on the Caucasian population and therefore we are not certain about the efficacy and safety of current medications and treatments in this population. It is important that future studies be more inclusive of Americans from various ethnic backgrounds so that we can ensure optimal health for all! ■



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