

Heart TALK

Heart-healthy and Stroke-free Living with Amy L. Doneen, MSN, ARNP

Vol 22 Holiday 2013



From Amy Doneen

Amy Doneen, MSN, ARNP

Happy holidays, everyone! It's incredibly hard to believe that Christmas is less than a week away and a new year upon us in less than two!

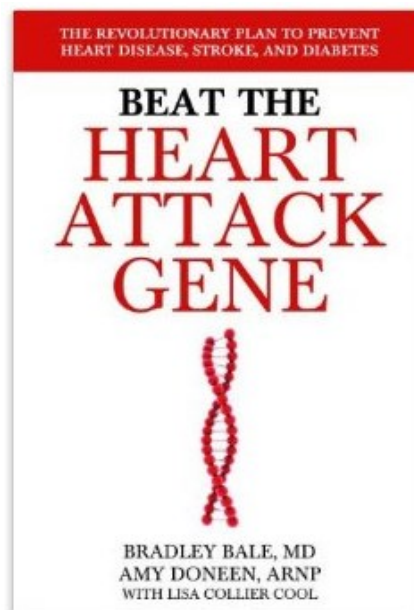
2013 has been a very rewarding year in that The HASPC has touched many more lives. I can't tell you what a privilege it is to work with the patients I do, to use cutting edge diagnostics, and to provide customized treatment plans to extend the lives and improve the health for those in our care. I'm truly blessed.

I am especially pleased that the mission of the Bale/Doneen Method will be expanded with the impending release of our book, "Beat the Heart Attack Gene," co-authored by Dr. Bradley Bale and Lisa Collier Cool.

With the information and case studies presented in this book, it is our hope that many more lives may be saved as others learn that the current standard of care is simply not enough when it comes accu-

rately predicting the likelihood of heart attack and stroke—and preventing them from occurring at all.

As a peek into the book, this issue is dedicated to an excerpt that highlights one of our HASPC patients, Camille Zaleski. Her story is remarkable, but sadly what happened to her is not as unusual as one might think. I hope you enjoy your sneak peek inside! (Excerpt begins on next page.)



The book is scheduled for release on February 4, 2014. Should you choose to do so, you can [pre-order a copy on Amazon.com](http://www.amazon.com) for 30% off the regular list price.

Thank you for your support and for being an inspiration. My best to you always,

~ Amy



Co-authors Dr. Bradley Bale & Amy Doneen, MSN, ARNP

**BEAT THE HEART ATTACK GENE:
A Revolutionary Plan to Prevent
Heart Disease, Stroke, and Diabetes**

www.BeatTheHeartAttackGene.com



Important Dates

February 4—Book is Released!

February 20 — Book Signing at Auntie's Book Store in Spokane at 7:00 p.m.

February 22 — Women's Red Dress Luncheon and Book Signing in Spokane. Get ready to wear red and celebrate women! Time & place TBA.

If you enjoy this newsletter, please pass it along to a friend or family member who may find it helpful.

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An Excerpt from “Beat the Heart Attack Gene”

How Standard Care Can Fail Patients

When Camille Zaleski had her annual checkup, her regular doctor was on vacation. Another MD gave her good news. “After checking my blood pressure and cholesterol, and plugging the numbers into a software program on his PalmPilot, he said my chances of having a heart attack in the next 10 years were less than 1 percent,” says the credit manager from Peoria, Arizona, then age 40. She went home reassured that her heart was healthy—and was almost certain to stay that way.



Five months later, shortly after arriving at work, Camille felt nauseated and lightheaded, with an irregular heartbeat. “I thought I was having a panic attack, because I was under enormous financial stress. My husband and I had just bought a new house, and three days later he was laid off from his job. I was worrying all the time about how we’d pay the mortgage.” At lunchtime, she felt so ill that she put her head on her desk, hoping that after a little rest the dizziness would clear up.

“By one o’clock that afternoon, I was having trouble breathing, and I felt like an elephant was sitting on my chest.” But she still didn’t consider her symptoms to be serious. “Three years earlier, I had the same kind of breathing problems climbing the steps to my doctor’s office and passed out, falling down the flight of stairs. That time, my doctor said it was an anxiety attack and put me on anti-anxiety medication and an antidepressant.”

She grew so dizzy that she lay down on the floor by her desk, afraid that she’d faint again. At three o’clock, she asked a coworker to call her husband, who rushed her to the emergency room. “By the time we got there, I had pulsating waves of pain in my left arm and it felt icy cold,” she recalls. “The triage nurse put something on my finger and said my oxygen level was OK.” She was left in the waiting room for 45 minutes,

while a man with a foot injury was treated ahead of her.

By the time her name was finally called, she was in such agony that she could barely stand. Tests showed that Camille was in the throes of a massive heart attack. “The doctor said that if I’d waited any longer to go to the hospital, I would have died, because there was no blood flow to the right side of my heart. I was terrified, and my husband almost fainted.”

Cardiologists threaded a balloon-tipped tube through her arteries, then inflated the balloon to open the blocked vessel, which was treated with a stent, a tiny, scaffold-like device that props the vessel open to restore blood flow. After three days in the cardiac ICU, says Camille, “I was sent home with a handful of pills and was told to call 911 if I ever had those symptoms again. I realized that the doctors were preparing me for my next heart attack, instead of telling me how to prevent it. At home, I was so scared that it would happen again that I couldn’t sleep at night.”

A Dangerously Unreliable Screening Technique

Almost everyone has heard stories similar to Camille’s, in which a relatively young person with no apparent risk factors suffers a seemingly inexplicable heart attack weeks—or months—after getting a clean bill of health from a doctor. And the usual reaction is to wonder, “How can that happen?”

Let’s take a closer look at how her doctor determined her risk. While the software program he used on his PalmPilot might sound like the latest medical technology, in truth, it’s just an electronic version of a screening tool that’s been around for decades, called the Framingham Risk Score (FRS). The scoring method is derived from an ongoing study of residents of Framingham, Massachusetts that was launched in 1948.

Still employed widely as part of standard care today, the FRS system uses a formula to predict the risk of heart attack in the next ten years based on the patient’s age, gender, cholesterol level, blood pressure, and smoking status. As a nonsmoking forty-year-old woman with normal blood pressure, Camille fell into the lowest risk category according to the formula, even though her cholesterol was mildly elevated. When the physician asked if she wanted a statin to lower her cholesterol, Camille was lulled into such a false sense of security by her FRS that she said no. Why risk the side effects of a drug when a heart attack was so unlikely?



An Excerpt from “Beat the Heart Attack Gene” (continued)

What’s Wrong with This Picture?

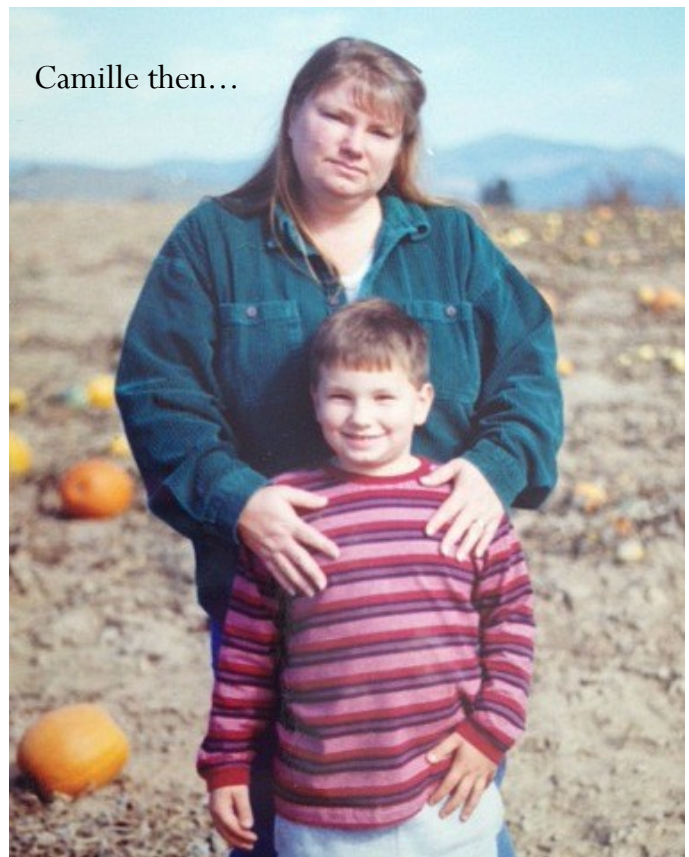
It’s not just the recently discovered or little-known heart attack risk factors that the Framingham system ignores. Its most glaring deficiency is its failure to factor in major threats to heart health that everybody has heard of. Camille’s risk score—and her doctor—overlooked even something as obvious as her weight, which had climbed since she gave birth to her son eight years earlier: At the time of her heart attack, she was carrying 246 pounds on her 5’4” frame, greatly increasing the threat of a heart attack.

Some studies suggest that obesity is just as dangerous to heart health as smoking, especially when excess weight is coupled with a sedentary lifestyle. Yet according to the Framingham system, despite being overweight and so busy with her demanding office job that she rarely had time to exercise, Camille was deemed to be as low a risk for a heart attack as a female triathlete the same age—even if the other woman weighed only half as much as she did.

A relatively new ten-year-risk calculator developed specifically for women, called the Reynolds Risk Score (RRS), also fails to take obesity into account. Introduced in 2007, it uses a formula that includes the traditional Framingham factors, plus two additional factors: if the woman has a parent who had a heart attack before age sixty and the woman’s level of a blood marker called high-sensitivity C-reactive protein (hs CRP).

However, at best this formula offers only a modest improvement over the Framingham system—and then only for certain women. The researchers report that in their ten-year study of nearly 25,000 women, their system was similar in accuracy—or for many people, inaccuracy—to FRS in making predictions for women at low or high risk for heart attacks. Of those deemed to be at medium risk according to Framingham factors, the Reynolds system reclassified 30 to 40 percent at higher or lower risk than their FRS suggested.

So far, RRS hasn’t been adopted widely, because relatively few healthcare providers use the hs CRP blood test in routine cardiovascular screening. And like the Framingham risk calculator, it can often miss women at high risk. For example, if Camille’s pre-heart attack numbers were plugged into the Reynolds formula, she would have been mistakenly classified as being at extremely low risk, creating the same false sense of security as did her Framingham score.



Incredibly, the still-popular Framingham system fails to take genes or family history into account. Over the past twenty years, an explosion of new research has revealed the key role that genetic factors play in determining cardiovascular risk. In Camille’s case, her family history held two potent clues that she was in far more danger than her doctor’s prediction suggested. The first clue was that Camille’s grandfather had type 2 diabetes, a disease that runs in families. Having it greatly increases the threat of a heart attack. Not only are adults with this blood-sugar disorder at as high a risk for heart attacks or strokes as nondiabetics who have already suffered a prior heart attack, but diabetics typically experience these calamities at a much younger age than nondiabetics.

Since diabetes is extremely common in people who are overweight or obese—and a family history of the disease further elevates the threat—Camille’s doctor should have checked her blood sugar. Had he ordered a simple, inexpensive blood test for diabetes that’s covered by almost all health plans—the two-hour oral glucose tolerance test (OGTT)—the results would have revealed that she was prediabetic, tripling her risk for a heart attack. Despite the well-documented link between prediabetes or diabetes—particularly if these conditions go undiagnosed and untreated—and heart attacks, the FRS and RRS don’t look at blood-sugar numbers.



An Excerpt from “Beat the Heart Attack Gene”

That’s a very dangerous omission. What most patients—and many medical providers—don’t know is that the vast majority of heart attacks have the same root cause as type 2 diabetes: a condition called insulin resistance, in which the body produces insulin, but doesn’t use it properly. Normally, this hormone, which is made by the pancreas, helps the body use glucose for energy. When people develop insulin resistance, their muscles, fat, and liver cells become insensitive to insulin, forcing the pancreas to crank out higher and higher amounts, trying to keep up with demand. Eventually, the pancreas becomes exhausted, and glucose (blood sugar) levels start to rise. Not only does this set the stage for type 2 diabetes, but it also starts to damage the arteries, which can lead to cardiovascular disease.

In Camille’s case, her family history also offered another red flag: Two close relatives had developed coronary artery disease so severe that they required open-heart surgery to repair blocked blood vessels. Many studies show that family history is one of the most important risk factors for developing heart disease, often at a younger-than-usual age—and the more affected relatives a person has, the greater the danger. While RRS does factor in family history, it includes only the patient’s parents—and only if they had heart attacks at a relatively young age.

One of the greatest medical breakthroughs of the past decade is the identification of four specific genes that dramatically boost cardiovascular risk. Millions of Americans unknowingly carry these common genetic mutations, and the cost of tests to detect them has plummeted. For less than the price of a mammogram, Camille’s doctor could have ordered a state-of-the-art genetic assessment, which would have shown that she’s a carrier of two dangerous genes: 9P21—also known as “the heart attack gene” because it powerfully increases the threat of cardiovascular events—and of the KIF6 gene variant, which not only magnifies risk for heart attack, stroke and sudden cardiac death, but also influences which particular statin could provide benefit. No doubt Camille wouldn’t have been so quick to turn down statin therapy if she’d known her KIF6 status.

The Medical Mindset

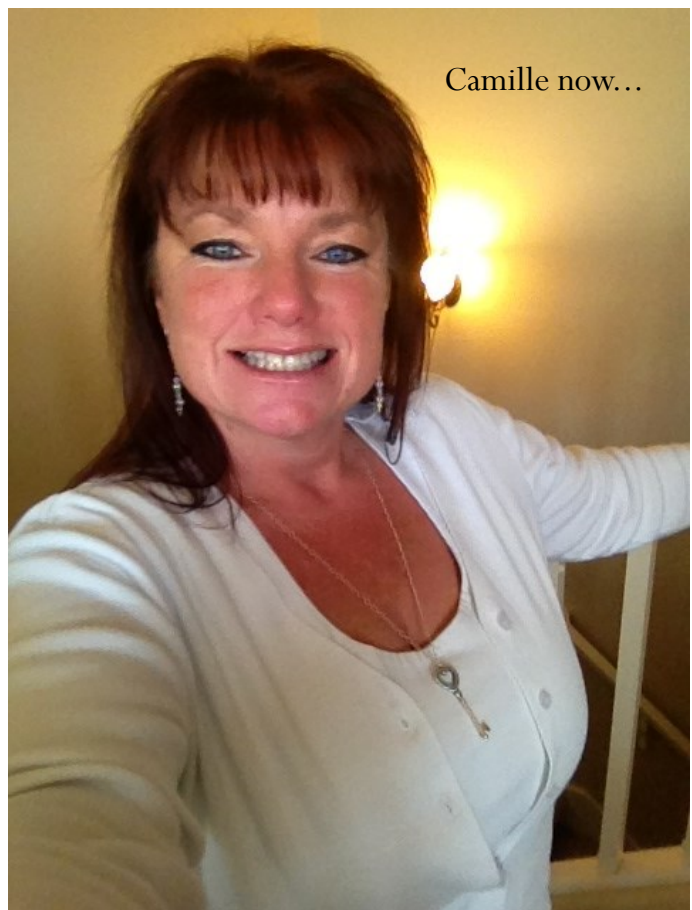
Add up all of Camille’s actual risk factors and her heart attack is no longer a medical mystery or a random quirk of fate. Instead, it was entirely predictable, had the clues been put together. And with the right care, it could have been prevented. Most doctors, however, are not disease detectives.

They’re trained to look for symptoms of active disorders and treat them, as Camille’s doctor attempted to do by offering to prescribe a statin for her slightly elevated cholesterol. For the

most part, healthcare providers don’t delve deeply into family history to search for genetic risks that could lead to future illnesses.

Why not? Two of the biggest reasons are time and money. In today’s harried healthcare environment, with insurance reimbursements shrinking, providers each may see sixty or more patients a day. Busy practitioners don’t have time to educate patients about why it is in their best interest to have a two-hour OGTT when most people aren’t worried about diabetes or insulin resistance and don’t consider themselves to be at risk. Nor do health plans adequately reimburse providers for the time necessary to educate patients, even if such education might ultimately save the patients’ lives. By far the faster and easier approach to heart attack prevention is to punch a few numbers into a computer and come up with a Framingham or Reynolds risk score.

Similarly, the economics of today’s healthcare doesn’t give physicians any financial incentive to rigorously investigate a patient’s medical history, genetic makeup, and lifestyle habits. Thus they can’t compile a personalized risk profile or determine which



Camille now...

An Excerpt from “Beat the Heart Attack Gene” (continued)

diagnostic tests would be most beneficial for that particular patient. Instead, they’re forced to rely on medical guidelines that are designed for the general population. Consequently, patients are screened and treated according to the average results from large studies, receiving one-size-fits-all care instead of tests and therapies tailored to their individual needs.

Another problem is that an avalanche of new medical discoveries, including new research findings that sometimes turn the previous medical wisdom upside down, plus new screening options, technologies, and treatments, has made it increasingly challenging for doctors to keep current on the best ways to manage an individual patient’s care.

Frequently, it takes a decade or more for medical societies to update their guidelines for patient care, further elongating the lag time before the average healthcare provider learns about new, evidence-based tests and treatments and incorporates them into a typical medical practice.

The big loser in our healthcare system is early detection. As you’ll learn in Part Two of this book, widely available, inexpensive tests can reliably identify the early signs of cardiovascular disease up to thirty years before it escalates into a silent killer. But many people with this potentially lethal disease smoldering inside their blood vessels miss out on early treatment that could stave off an impending heart attack or stroke because their doctors don’t give them the right screening tests. The same is true of insulin resistance and prediabetes, both of which can often be reversed if caught early, sparing patients the dangerous—and costly—complications of developing full-blown diabetes. Yet millions of Americans with these increasingly common diseases continue to suffer irreversible—or even fatal—harm simply because they were diagnosed and treated too late.

The Bale/Doneen Difference

At our heart attack and stroke prevention centers, we see many patients who have fallen through the cracks in standard care. Some have suffered heart attacks or strokes their doctors can’t explain, or like Camille, were sent home from the hospital with instructions to call 911 when their next heart attack hit. The scary statistic behind that advice: one in three heart attacks and one in four strokes occur in people who have already survived a previous cardiovascular event.

Other patients turned to us after their healthcare provider diagnosed them with cardiovascular disease—or one of its major risk factors—but didn’t offer a comprehensive heart attack and stroke prevention plan. Because these men and women weren’t

told how to protect themselves, they felt like ticking time bombs rather than empowered patients armed with potentially lifesaving strategies to manage their disease. Later in the book, you’ll meet a patient who actually considered himself to be “a dead man walking,” because his cardiologists had given such a dire prognosis that he believed that a fatal heart attack, like the one that killed his father, was both imminent and inevitable.

Our heart attack and stroke prevention method, which we’ve taught to hundreds of healthcare providers from all over the world in our American Academy of Family Physicians-accredited training program, is scientifically designed to detect and stop a silent killer: cardiovascular disease. All of the recommendations we make in this book are based on the latest research, such as the results of randomized clinical trials published in peer-reviewed medical journals. As a bonus, the treatments we advise, including lifestyle changes and action steps you can take on your own, also are highly effective at preventing type 2 diabetes. And if you’re already diabetic or prediabetic, the plan we present in this book can halt further damage—or in many cases, can even reverse the early stages of the disease.

Throughout the book, you’ll find the scientific evidence to support each test and treatment we advise, so you can show it to your healthcare provider and ask for optimal, personalized care. Our goal is to empower you to take charge of your medical destiny by identifying your true risks, what’s really causing them, and the best treatments, including lifestyle changes, to overcome cardiovascular perils. As you’ll discover in the next chapter, the comprehensive prevention we recommend uses inexpensive, noninvasive tests—along with information that may already be in your medical chart—to answer four crucial questions. Learning the answers—and acting on this information—could save your life.

