Kris Kleindienst (00:00):
Almost exactly a year ago, I had a heart attack out of the blue. I wasn't someone that people were saying I was a candidate for that. Obviously I survived. It's a little damaged. So this has been a year unlike any other, for me.

Seán Collins (00:21):
One thing that really strikes me is that you were really athletic. You're trim, you were active. You've, you run a business, maybe a little Type A, but you were a runner too, if I remember correctly. Or maybe you still are.

Kris Kleindienst (00:33):
I was a runner. But truth be told, I had gone through a pretty stressful four years or so, and I had, as they say, let myself go. I was doing some pretty intense care taking, still running my business. There was trauma involved with the caretaking. There was just so much to do that I put my own self-care on the back burner. I am a high energy person. Type A is probably a good description, so, you know, long hours doing lots of stuff. I own a bookstore that can be a very physical job. But yes, I'm the person someone looks at and says, you, you had a heart attack. I don't understand.

Seán Collins (01:23):
That's Kris Kleindienst, owner of Left Bank Books in St. Louis. A year ago, she joined the ranks of women living with heart disease. She found out that she had had a heart attack and that one of her coronary arteries, the vessels that supply oxygen to the heart muscle itself, one of those arteries was completely blocked. So they placed a stent, a wire mesh that helps keep a narrowed blood vessel open for business, then came rehab, and the task of making changes in her life. We'll hear more from Kris Kleindienst throughout the show today, and we'll also be hearing from Dr. Lori Tam, a cardiologist at the Providence Heart Clinic, St. Vincent in Portland, Oregon. I'm Sean Collins, and this is the Hear Me Now podcast. Today, a woman's heart understanding heart disease in women. Here's Dr. Tam.

Lori Tam M.D. (02:18):
Over the years, the whole medical field really hasn't thought of heart disease as a, as a woman's disease until kind of in more recent years. And I think only now I would be more aggressive with management education and prevention. You know, there are a lot of women that I take care of who said, well, you know, the doctors have mentioned that maybe my cholesterol's been a little bit high, but they just told me, lose some weight. Work on your diet. We'll check it again. You know, and, but nobody actually jumps the gun and puts them on a cholesterol medicine when it's been high for 10 years. At what point do you say, you know, do we just start something? Do we need to treat it rather than just talk about it? Right. So I think that in recent years with these you know, increased awareness campaigns about heart disease and women, and how women are just as, as likely to have heart disease and sometimes more so in certain cases these are symptoms that we need to be aware of and and also be empowered to, to ask our doctors about what our risks are, how we, what we can do to really change our risk and reduce our risk.

Seán Collins (03:16):
Right. The numbers are really alarming, I think for a lot of laypeople to think that I isn't one in three women in the US dies from heart disease.

Lori Tam M.D. (03:26):
It's true. You know, one in 31 women die from breast cancer. One in three die from heart disease. So heart disease is, is certainly a, a very big public health issue and one that can't be preventable about 80% of the time. You know, heart disease, there are certain things you can't prevent. There are genetic factors. There are certain inherited conditions, but many of the things that drive heart disease that we can control are lifestyle measures. And it, it, we can decrease our risk by changing how we exercise, what we do, how we eat and the things that we do in our life to kind of work towards living a heart healthy life. So it is astounding. And, you know, the other, the number to keep in mind is that one in two women will die from either heart attack or stroke. So

that's half of us. You know, when I am in a room kind of talking to, to women about this issue and have 'em ask them to look right, look left, half of them are not gonna be there sometime in the future because half of them will die from heart disease or stroke, one or the other.

Seán Collins (04:33):
You know, the popular understanding is that that women often have different symptoms than men when they have heart disease. Can you con sort of give us a thumbnail idea of what the differences are between the way mm-hmm. <Affirmative> heart disease presents in men versus women, or women versus men?

Lori Tam M.D. (04:53):
Well, I think for the longest time, women's symptoms were often under-recognized because not every woman has chest pain, you know, and chest discomfort, chest pain is still the number one symptom that women have when they present with a heart attack. But there's also a myriad of other symptoms that could kind of be their sign that they're having a heart attack. For example, some women will say they have significant shortness of breath with exertion. Some women will say that they have this sense of, well, of doom, you know, they just don't feel well. They're nauseous, they're sweaty. Sometimes they describe their, they don't use the word chest pain when they're having chest discomfort. They often will say it's a pressure or a tightness or a heaviness or a burning. So, you know, when you start using those other terms, the doctor will say, are you having chest pain?

(05:40):
They'll say, no, but you know, but it's actually, if you, if you talk to them a little bit more and, and take their history, they'll say, yeah, I have this pressure, this heaviness. I feel like there's an elephant sitting on my chest. Or sometimes it's a little lower. It's in the epigastric region, which is right below the chest in the upper abdomen. And sometimes I've had women that sit all night at home taking Tums and a whole bottle of Tums later. They're like, I'm still having, you know, this discomfort. I'm sweating. Yeah. I'm

nauseous. And then they finally show up to the emergency room. But that's after a whole night of essentially heart muscle damage, because in cardiology we talk about time is myocardium. A myocardium is the medical word for heart muscle. And if you go for an extended period of time without blood flow, adequate blood flow to your heart muscle, guess what?

(06:24):
That muscle dies. And you know heart muscle that's, that's damaged like that often will result in permanent heart failure down the road, or a much higher risk of arrhythmias that can result in cardiac arrest where your heart just stops. So you know, I think because the symptoms can masquerade as other things, sometimes people don't recognize that maybe the symptoms are having, or due to a heart attack. There's been studies that have done, been done over the years that look at, you know, how long it takes for a woman to present to a first medical attention from the onset of heart attack symptoms. It's hours and hours after a man would present. So sometimes because we don't recognize it, sometimes it's because we're, we don't believe it. You know, we don't think that we're at risk or but I think that because of that delay in seeking medical care sometimes the outcomes are much worse for women when they have a heart attack.

Seán Collins (07:15):
Well, the, the old story about men used to be that the first symptom of a heart attack was denial. Yes. That it does seem to be common to both men and women, that there's a, a willingness to sort of discount what, what you're feeling. Oh,

Lori Tam M.D. (07:31):
Absolutely. I think it's easy to kind of explain away a lot of things and especially when we don't wanna believe that something as serious as a heart attack is happening to us. But I think it just illustrates the importance of being really proactive, being your best own personal best advocate. You know, I think that if things don't feel right and it's, it's okay to go to the emergency room, and if it's a false alarm, that's okay. But an

unrecognized heart attack and have consequences are much far reaching and much more serious. So I think that it's important to be aware of those symptoms and to think that, you know, it's okay if it's a false alarm. I don't have to be embarrassed by that. I think a lot of women are caregivers. We take care of our families and and we sometimes put our own needs and our own kind of issues last. But I think at the end of the day, you're not gonna be around to take care of them if you're not around. So I think that more reason to be aware to be proactive and to really pay attention to how you feel

Seán Collins (08:33):
Your colleagues who are primary care physicians already are taxed with lots to do in a 15 minute encounter with a patient. Should there be a rethinking of what the screening mechanism is for looking out for symptoms of heart disease?

Lori Tam M.D. (08:52):
You know, I think it really comes down to despite all the the pressures in primary care, and it's a lot of pressures. I have all the respect for my primary care colleagues. I think it's still important when we do have our interactions with our patients to take some time to understand their cardiovascular risk because heart disease is the number one killer of both men and women in the us. You know, the majority of us will die from heart disease if you don't die from something else, you die from heart disease. And that risk goes up as we age. And it is a modifiable, you know, disease process, meaning it, it can, it can be affected. The impact of what we do can really change the trajectory in a number of cases. Hmm. So it's important to know your numbers, you know, to when you see your doctor, to know kind of the key indicators in terms of your risk for cardiovascular disease.

(09:45):
So know what your blood pressure is and what a healthy number should be. Know what your blood sugars are, know what your cholesterol numbers are. Know what a healthy body weight is for you, because those are really key indicators that can affect

and help us understand our risk. And then in addition to targeting, kind of getting these patients to the goals that they need to be, sometimes there are other things are important, you know, taking a good family history. If there's a number of people who've had premature heart disease in their lives that may be a reason to be a more aggressive with screening. You know, there's a test called a coronary calcium scan that we're doing a lot more these days, especially in patients who've are at least moderate risk for heart disease based on cholesterol numbers and age or have had a family history, premature heart disease.

(10:27):
Will do a coronary calcium scan in a number of these patients, even if they're not symptomatic. And we're looking for essentially silent, calcified plaque buildup. Calcified coronary calcium is a corollary for calcified atherosclerosis and plaque. Sometimes I've got, you know, healthy people that come and see me and they're like, well, I'm 45. I'm a marathon runner. I eat real well. But my dad had a heart attack at like 47, so what should I do? You know? So I run a coronary calcium score sometimes in these people, and they come back at, you know, really, really high scores that there's already a lot of silent plaque buildup that we're just not aware of. And once you're empowered with that knowledge, you know that, gosh, this person probably needs to be on a cholesterol medication, a statin at this point, to prevent further plaque progression. So you, you know, there are tools now that we have at our disposal to kind of try to stratify risk earlier and in the appropriate patient. That might be a good test to do. So I think that I, I'm seeing our primary care colleagues using that test increasingly more to try to identify who really needs to be on these aggressive prevention medicines, maybe at an earlier stage.

Seán Collins (11:32):
Hmm. How is that test performed?

Lori Tam M.D. (11:35):

It's a CAT scan, takes about three minutes, three to five minutes. It's done in radiology, and it's essentially just a CT scan of the chest, and it looks at specifically how much coronary calcium or calcification or hardened a coronary for hardened atherosclerosis per plaque in the arteries of the heart. So it's quick, easy to do. There's a little bit of radiation. It's, it's still relatively low compared to CT scans that involve contrast eye. But it's a one-time scan that we do to kind of assess your risk. Not everybody needs it, but in nu people who've had high cholesterol numbers for a long time where they are trying to decide whether we should treat them or not, sometimes it's very helpful because if your score comes back at zero, well, the likelihood of a major heart attack in the next five years is really low. You really have no significant calcified coronary calcified plaque in your arteries. But if the score's really high, then obviously there's already some silent, you know, calcified plaque formation in the arteries.

Seán Collins (12:37):
You mentioned that you own a bookstore, it's called Left Bank Books. Yes. And the reason I bring that up is you had a trip to Paris mm-hmm. <Affirmative> little over a year ago. Tell me about that.

Kris Kleindienst (12:50):
So that's the, that's the long story of my heart attack. I had been hoping to take that trip the two years before. Covid time is very confusing. The, the week of the lockdown was my first planned time that I was going to go for my first trip to Paris to see, for example, the left bank and visit all the places associated with all of the people that I think of

Seán Collins (13:23):
All the expat writers and exactly

Kris Kleindienst (13:25):
All the expat writers, even some of the French ones the lesbian ones, the, you know, Gertrude Stein and Alice b Tolas and Sylvia Beach with her iconic bookstore,

Shakespeare and Company. This was, you know, a bucket list trip for me. I was really pushing it to get everything buttoned up before I left. And a friend of mine happened to have a schedule that coincided with mine, and we flew together, which turned out to be really good. Got off the plane in the Charles Tagal airport and immediately had what I call an episode, something that had never happened before. I got like this weird nauseated feeling all over my body, not my stomach, but my body. And I felt like some chills and dizziness, and I thought I was, I would faint or possibly worse. And then it passed. I was in the airport, but my friend was really concerned, and the airport medical people came, and they have their own little mini clinic there.

(14:31):
And they took me there and did an E K G and said they didn't see anything, but they, I should go get this checked out at an emergency room. So I, my first thing of going to Paris was to take an ambulance to an emergency room, <laugh> not the kind of tourism I was hoping for. And <laugh>, I spent the rest of the day there, mostly as you do in any hospital, sitting in a room by yourself. They wouldn't let my friend back. She speaks French because of Covid. Right. so it was a little difficult, the language barrier. In fact, it was impossible with all of the people I was actually seeing. They did an E K G didn't find anything as far as I knew, I couldn't really tell for sure. And I didn't know why they were continuing to keep me.

(15:24):
This man just kind of came in and started rattling French at me and grabbing, disconnecting me to take me down the hall somewhere. And I didn't know where we were going or what we were doing. <Laugh>. And somehow we managed to establish I was not Swiss or German because he saw my name Right. That I was American. This was not a popular thing for him. And I made a terrible mistake of as he was whisking me down the hall to some doors with a testing lab name that I didn't know what it meant. Saying, I, I, I, I, you know, no, I can't do this. I'm American. I don't have insurance and or don't have French insurance. And I am certain that what he heard was you stupid French man, I'm American. You know, do what I say or something.

Right. Because he just flipped into a very like, oh, American. He actually said that several times. And he whipped me around the other way, took me down some other hallway, sort of telling and pointing at me to his friends as he went along American American. And I was just so sunk. I was like, the last thing I wanted to be was the ugly American and stuff was the first thing was

Seán Collins (16:44):
The American with a French speaking friend in the waiting room.

Kris Kleindienst (16:47):
Yes. <laugh>. So eventually the doctor came, the doctor who had been directing my treatment, who I had not yet met and or even knew was involved. He was a lovely man, and he spoke English and he explained, you know, what was going on, eight hours in. And I said, you know, I've been feeling fine ever since. I promise you I will go see my doctor as soon as I go home. I just got here, you know, just landed and wanna

Seán Collins (17:24):
See the left bank

Kris Kleindienst (17:25):
<Laugh>. Yeah. And wanna see the left bank. He was very nice about it. And he said, okay. But I got released with a prescription for antacids which I filled and dutifully tried to take. But what happened was, you know, of course you have jet lag, which I didn't know how to read it would, is my first trip that long. And I never felt like better, better. I never got enough energy to really enjoy being a tourist. I actually started having more episodes, and they started being sort of worse and, and gradually happening more often. And at one point I did call my stateside physician, but her firewall was so thick. And the woman who was that firewall, English was her second language. And I had to explain to her what Gaviscon was, and I just begged her, I just need like five minutes total. I really feel it would be helpful if I could talk to the doctor. Instead. What

happened was the, her pharmacist called back with another prescription for antacids. And I just thought, well, I know this is not that, but I don't know what it is. And

Seán Collins (18:50):
You must have been terrified.

Kris Kleindienst (18:52):
I was a little, yes.

Seán Collins (18:55):
Did you think it was your heart?

Kris Kleindienst (18:57):
I was r I think in the back of my mind, I knew it could be, but I kept thinking it's maybe it's a hernia may who, you know, I just couldn't anything but that I went straight to bed. When I got home, I thought, well, stress, you know, I'll just sleep in my own bed. I'll be fine. No, by three 30 in the morning, I felt so much worse. Now my jaw was clenching up, my teeth were chattering uncontrollably. I was like, okay, this is not okay. And anyone who knows me would say, call 9 1 1. Instead, I called first my son who didn't pick up his phone, which is typical. And then I called my friend next door. It was three 30 in the morning. She answered her phone. I said, Lori, can you take me to the emergency room? She's like, sure. I was on a table right away, <laugh>, the way I tell this story is like six women in blue scrubs suddenly were all over me, you know, ripping off my clothes and sticking me with EKG plugs. And it was kind of exciting. And then the the doctor there, she said, you're having a heart attack. And then they just went into overdrive and started a different kind of prep. And, and the cardiologist came on call, you know, not at the hospital, seemingly immediately. And he just, they whisked me down to the surgery room. And I'm like telling Lori as we're going, like, where to find my will and what to tell my son if I didn't make it. Yeah.

Seán Collins (20:39):

That early morning a year ago, Kris Kleindienst had a blocked artery opened. There is another type of heart attack not caused by cholesterol blockage in an artery. Those are called MINOCA.

Lori Tam M.D. (20:53):
So MINOCA stands for myocardial infarction in the absence of obstructive coronary artery disease. So these are types of heart attacks that occur when there's no severe blockage in the arteries of the heart. It's not due to you know, typical atherosclerotic plaque. And it's, many of these are more common in women, but they can happen in men too. But it's a whole new category of a different category of heart attacks. So the risk factors often are different. So for example there's a type of heart attack called a spontaneous coronary artery dissection or scad, where it's not due to plaque buildup, but it's due to a tear in the inner lining of the blood vessels. And this tear can occur more commonly in women, maybe because of estrogen and hormonal reasons. It also happens more commonly in pregnant women or recent, or women who've recently delivered because the estrogen levels in their system are higher.

(21:48):
And we presume that this makes their blood vessels more fragile. And they're more prone to tears and dissections. And when there's a dissection in the artery, you can form a collection of blood that essentially kind of stops off, that cuts off the blood flow, and it acts looks, and it is a heart attack, but it's not from a blockage. It's not from a cholesterol blockage. So usually stenting is not what we would prefer to do this. These often happen in younger women or in people who are really doing really strenuous exercise. Sometimes they have some underlying vascular abnormalities, something called fibromuscular dysplasia that puts 'em at higher risk. But these are people you don't usually expect to have heart attacks. There's another type of heart attack called broken heart syndrome in the layman kind of media, but it's, it's called stress cardiomyopathy, where some really stressful event actually triggers that, a response where the heart gets really stunned.

(22:43):
It's like a rush of adrenaline to the heart. The heart can't handle that massive stressor. And you will have a heart attack that is due to a stunned heart. And sometimes it's due to something that is a horrible event. You know, I've had women one woman whose college-aged son had just drowned in the school swimming pool. She got the news and, you know, within 10 minutes started getting severe chest pain. Mm-Hmm. And you know, had to come into the hospital. And her cardiac enzymes, troponins were way up. She had abnormalities on the E K G, but we did an angiogram. Her angiogram was clean, there was no blockages, but she had some characteristic findings on the echocardiogram, the ultrasound that showed that portion of the heart wasn't moving. And it was very classic for stress cardiomyopathy. Luckily most people with stress cardiomyopathy recover with medications and some time, and the heart function usually returns to normal, but you can get real sick for a while there until the heart returns to normal.

(23:39):
There's another type of heart attack called microvascular disease that sometimes can cause heart attacks, not commonly, but these are not the big arteries that get plugged up. It's the little micro vessels that you cannot see. And those arteries can spasm, they can narrow down, they can cause you chest pain when you exert yourself. And then there's an actual condition called coronary artery vasospasm, or the arteries that feeds your heart. There's no cholesterol buildup in them, but once in a while, just like a muscle, they'll, they'll spasm down. And the inner lining of our blood vessels actually have a a smooth layer of smooth muscle. Right. So the muscle can spasm, just like any, you know, muscle anywhere. If it spasms and cuts off blood flow, well it acts looks, and it is a heart attack. But most of the time, certain medicines like nitroglycerin and other things allows this muscle to kind of relax, or sometimes time alone will allow it to relax and open up. So you know, people can have heart attacks and not have a cholesterol plaque. We have to treat them differently. We have to recognize it, and we have to put them on the appropriate medicines to prevent that from happening.

Seán Collins (24:40):
So a, a woman who hears those five or six types of heart attacks that are Yeah. Not due to cholesterol buildup. How is she supposed to process that information? Like how do you screen for that? How do you mm-hmm. <Affirmative> pay attention to your own symptoms to be informed about what could be happening to you?

Lori Tam M.D. (25:03):
So, you know, many of these things, there's really no for these, you know, non-obstructive, plaque related heart attacks, menka heart attacks. There's not a screening test. It's not like I can check your cholesterol or do a coronary calcium scan and it's gonna be abnormal, because most of the time in these patients, they're normal, you know. But I think the, because they're overall still rare causes of heart attacks it's just important to be aware of what signs and symptoms of a potential heart attack are, so that if they do happen to you, you're taking it seriously. You're seeking medical attention, you're getting your cardiac enzymes checked and an EKG checked because those are the things that can tell us whether there really is a heart attack that's occurring or, or, or, or potentially occurring at that time. I think that if a woman is getting exertional symptoms, especially like activity gives you more chest tightness, pain pressure, shortness of breath, those are symptoms we should pay attention to.

(25:57):
You know, people will say, gosh, when I walk up the stairs, I'm starting to get this heaviness or this pressure. Hmm. Sometimes it radiates to other areas, you know, so I've had women that come in with jaw pain or they go to their dentist cuz they've got jaw pain and the dentist looks, and there's nothing wrong with your teeth. But then if you see, talk to them and ask them, well, when do you get jaw pain? She's like, well, yeah, when I'm on the treadmill, you know so that's probably just referred pain from a cardiac issue, or maybe it's in the left arm. That's another common place that people will feel it. The nerves in the body crosstalk with one another. Heart pain can be felt in different areas. So I think that if you're getting exertional symptoms, whether it's severe shortness of breath, chest discomfort if that's not normal for you, then you, you need

to go ahead and have it checked out. Because really until we've done the appropriate tests, we don't know that it's not your heart.

Seán Collins (26:46):
Can you talk to us about hormone replacement therapy? What sort of issues should women pay attention to at menopause or, or frankly, with birth control as well mm-hmm.

Lori Tam M.D. (26:57):
<Affirmative>. Yeah. Really in any stage of their, our lives really. So, you know, our natural estrogen is protective. Yeah. You know, women don't have as a high of a risk for heart disease until after menopause. And we tend to get heart disease, you're on average about 10 years later than the average man. If all the other risk factors are the same, because we have the natural protective effects of our natural estrogen until we start to lose it. So after menopause, you'll see that a woman's cholesterol numbers tend to go up. You'll see that their heart disease risk starts to go up more after menopause. Not that premenopausal women don't get heart attacks. We still can, but it's more, more rare. And your heart disease risk goes up with age. And so natural estrogen, your own estrogen is protective until you start to lose it.

(27:43):
But there are things like birth control pills, which have you know, a significant supernatural amount of estrogen. That's how it kind of suppresses your ovaries into not ovulating. You know, birth control pills increase your risk of blood clots and strokes. Women who smoke and who are older than 35, we know that their blood clot risk and stroke risk is much higher on birth control pills. So we just need to be aware of that and know that there's certain patients that may not be appropriate candidates for it. We know that women who've had a prior pregnancy complications such as pre-eclampsia, where the blood pressures go really high mm-hmm. <Affirmative> gestational hypertension, gestational diabetes those women are more prone to heart disease and

their risk of heart disease and stroke are probably at least two times higher later in their lives just because they've had that problem earlier in their life.

(28:37):
There's probably, it identifies women that probably are have, you know, certain un underlying vascular issues and things that may put them at higher risk later on. We know that hormone replacement therapy in early kind of younger women are just going through menopause. It's fine. You know, I think it's fine for symptom management. People do okay. But in older women, especially women older than age 65 long-term chronic hormone replacement therapy being on estrogen for more than five years at that point if you're older than 65 and you've been on for more than five years, your risk of stroke and heart attack go up as well as your risk of breast cancer. So I think it's important for women to know that yes, early in menopause, if you need some estrogen to help kind of get you through the perimenopausal symptoms, it's acceptable. But as you get much older we need to try to wean you off because physiologically that's not what your body would be doing anyway. You know, we make less and less estrogen as we get older. That's a normal thing that happens. And if you try to give patients extended periods of time with estrogen as they're older, you start running into the plaque issue, you start running into stroke risk and breast cancer risk. And that's probably not worth it for most of our patients

Seán Collins (29:54):
Is the process of rehab after an MI different for women than, than for men.

Lori Tam M.D. (30:03):
You know, we put them through the same cardiac rehab program and it's for most patients, it's covered by insurance. It's a monitored, medically monitored exercise program. After a heart attack, we put heart monitors on you EKG leads, and we gradually exercise you under the supervision of an exercise physiologist and a nurse. And we make sure that you can increase your level of exercise safely and also kind of reach a, a level of reconditioning that is gonna be helpful for maintaining heart health

later on. So I think that the process of rehab very much is similar for both groups, but we want you to gradually work up to it. We wanna make sure you're doing it in a safe way and we monitor your hearts and your heart rhythm to make sure there's no concerning arrhythmias or problems that we see during the rehab.

Seán Collins (30:50):
Are you aware of any two cardiologists, families trying to make lifestyle changes living with a partner who's, who's doing the same thing?

Lori Tam M.D. (31:00):
Yeah. You know, I have plenty of patients who both have heart disease. And I will say that just like quitting smoking, you know, when one partner quits smoking, the other's still smoking, it's almost a guarantee that the other partner isn't gonna be able to succeed. Right. Because I think that because heart disease is very much a lifestyle disease in a number of cases, not the only thing, but a number of of cases are, or very much impacted by lifestyle. You both have to walk the same walk and talk the same talk. You know? So when I had, even if I have one patient that has a heart attack and I'm doing cardiac rehab with them, I'm sending them to a nutritionist to kind of get some education about what a heart healthy diet should be. I usually ask them, you know, who's the cook in the family? If it's your wife? Or if in the other case, sometimes if it's your husband, bring your partner along when you meet with a dietician mm-hmm. <Affirmative>, because it needs to be something that you both can institute and a life that you need to live together. It's gonna be better for the both of you in the long run. But these lifestyle things they're, they're usually go hand in hand. You know, you have to both live that life.

Seán Collins (32:06):
Yeah. I, you know, I bring it up a little bit because I, I was lucky in that first cardiology experience that I had. The practice was really well integrated. There were nutritionist Yes. There, there were psychologists that were part of the practice. Yeah. The, there was a 12 week sort of education program that people with MIs would go through. Mm-

Hmm. <affirmative>, there was part, part group talk and part learning new sort of lifestyle changes. You know, it, they did a very good job Yes. Of empowering the patient to sort of think through changes mm-hmm. <Affirmative>. And one of them was, you know, this sort of alert about depression, but it wasn't addressed to the patient, it was addressed to the spouse. Mm. Saying mm-hmm. <Affirmative>, look out for this. Be be on the lookout. And I wonder what you, you know, sort of hearkening back to what you said at the beginning of our conversation about how women traditionally have this sort of caretaker role mm-hmm. <Affirmative> who's, who's looking out for them. That's the thing that worries me, is that mm-hmm. <Affirmative>, it, it seems more natural for women to look out for the male Yes. Partner who may have had heart disease, but is someone looking out for her?

Lori Tam M.D. (33:20):
You would hope so. You know, I think that partnerships are partnerships because there's two, right. And, and in that in that relationship. So you would hope so. But I think it, it's true that women, I think sometimes these issues aren't as readily apparent or recognized because they've been in a caregiver role. Maybe their spouse is just not attuned to and, and used to being in that role otherwise for her. Although I will say, you know, I gotta give men some credit. I've got a lot of male, a lot of female patients who have, you know, wonderfully supportive husbands and spouses. I've got elderly patients where, you know, they're both 90 and he's holding her hand, walking her in because she's unstable, you know, and, and she's, he's the one that's making sure she comes in for her labs and gets her medicines.

(34:07):
Right. We don't choose kind of who's gonna be the healthier one and what's gonna happen to who, you know, these are the things that come, what may come with life. And but I do agree that you know, I think it's the family needs to be aware that these are things that can happen after a heart attack. Depression is a real thing. And not just after heart attack, really, after any, any, you know, major stressors or setback in one's life. Right. the primary care doctor, sometimes if they, you know, know them well, and

you've had this long relationship with your doctor, they might be able to, you know, ask some questions that kind of product out how you're doing. You know, I, I think that at the end of the day, they'll, we still have to be our own best advocate if things don't feel right. If you need help, you know, I think it's, it's also our, the patient herself for her own responsibility also to speak up and, and ask for that help and hope that we can provide that to her. So I think that depression is very common and much more common than we realize. And, you know, they've done, many studies have shown that people that are depressed, it actually impacts their heart health. You know, their risk of heart attacks and heart disease go up if depression is untreated.

Seán Collins (35:17):
Yeah. Dr. Tim, you've had you've given us so many wonderful insights into this and it, there are lots of moving parts and I'm, I'm trying to be an advocate here for the bewildered listener who's wondering, how do I, how do I keep all of this mm-hmm. <Affirmative>, you know, straight, how do I, how do I look out for myself? What do you say to her? What do you say to the woman who feels a little bewildered by all the data that's coming at her mm-hmm.

Lori Tam M.D. (35:50):
<Affirmative>. Well, I think that I think there's a few things that comes down to, right. So the it's important to know what your risk factors are, what you can do to change them. So talk to your doctor when you do your annual visit with your primary care. It's easy to say, you know, like, yeah, you know, once I turn 40, I know that the re the recommendation is to get a mammogram. If you're after a certain age, you get colonoscopies. So, but I know the heart disease is, you know, the biggest killer of women in the us So what are my, what are my risks for heart disease? Should we talk about how I can reduce my risk? Are there any tests that I need to do that would be appropriate to assess my risk? So I think that's a, a time when you do your annual physical, when you really should talk about that with your primary care doctor, that's an opportunity to address those things.

(36:35):
And then secondly, I think it's being aware of symptoms and what to be aware of. And if you have any of these symptoms of concern, take it seriously. Talk to your doctor about it. If these symptoms are acute and definitely getting worse you know, go into the emergency room, get your ekg, get your cardiac enzymes and get it evaluated because you don't want to sit on it for too long, because sometimes it may be irreversible if you wait too long. And then I think that, you know, there are some key lifestyle choices I think are important for everybody to try to maintain, right? So, current recommendations of the American Heart Association is that we do moderate levels of exercise about at least 150 minutes a week. So that's 30 minutes on average, five days a week. If you do longer sessions, you can do fewer days, but you should try to reach for that.

(37:22):
That's a, that's an attainable goal, you know, and, and maybe just like walking the family dog after dinner or getting an exercise bike and, you know, hopping on at the end of the night. You know, I, during the, when the pandemic started, when my kids went to bed, I got a cheapo exercise bike off of Amazon, and I watched the news and did my 30 minutes or 45 minutes, right? Because it was just, you know, a way to kind of mindlessly do something that was keeping me active while I was doing something else anyway, I was watching the news, for example. So I think we need to find what works for us. We have to find the active things that keep us healthy, that we enjoy doing. You know, sometimes it's doing the yoga class or bar class of the other moms in the class, or if you like, you know, fishing and hiking and all those other things.

(38:06):
We want you to do those things. We want you to be active, but find things that are enjoyable to you, so you're more likely to maintain it. And then you know, for most of us eating a Mediterranean type diet, we feel like we'll reduce the risk of cardiovascular disease. And a Mediterranean diet includes healthy fats like olive oil and fish, and nuts and avocados. Those are the good fats. They raise the good cholesterol, help you clear

the bad cholesterol, eat less saturated fat, less dark meat, less red meat, less deep fried things, less processed things. You know the processed and packaged foods that we have in our American diet has so much saturated fat, so much sodium that mm-hmm. <Affirmative>, it will increase everybody's cardiovascular risk if we don't really pay attention to that. And then, you know, sugar is really prevalent in our diet, and that's why there's, the obesity issue is much more of an issue.

(38:57):
People gain a lot of weight when they eat simple carbohydrates and sugar, you know, so the white bread, the white pasta, the refined foods, you know, if you stick to brown rice instead of white rice, whole grain bread instead of white bread, you know, choosing the healthier options when we can and substituting those in our diet will make a big difference in the long run. I think these are steps that all of us can can adopt and, and learn and just build into our lifestyles. I think it's the important thing is that you know, for those that have children, they grow up kind of reflecting the things that you've taught them, you know, so mm-hmm. <Affirmative>, if they've grown up eating you know, only white wonder bread and processed foods, that's the kind of taste buds and the, the things that they grow in affinity to, you know. But I think that if we adopt a heart healthy diet, if we educate and empower the women with the tools to live a heart healthy life, you're not just gonna improve her health, you're gonna improve the health of her family, her community, and everyone around her.

Seán Collins (39:58):
What a, what a good point. Dr. Lori, Tam, thank you so much for taking the time to talk with us today.

Lori Tam M.D. (40:05):
Oh, thank you, Sean. It was a pleasure. Pleasure talking to you.

Seán Collins (40:07):

Dr. Lori Tam, cardiologist at the Providence Heart Clinic, St. Vincent in Portland, Oregon, back to St. Louis now. And to my conversation with Kris Kleindienst,

(40:19):
Kris it's been a year, you're an awfully thoughtful person, a good writer. I'm curious what you're thinking a year into your cardiac recovery.

Kris Kleindienst (40:32):
Well, I'm thinking a couple things. As to how I got to that place where I actually had the heart attack. I think the cause as it were, was a badly broken heart. And that's very spiritual and mo emotional and social, you know, and the medical or biological things that were going on were being fueled by this just huge emotional, spiritual breakdown. I was in the midst of, and it was a very long slow one. And, and this was like, I wasn't caretaking anymore. I was a couple years past it, but <affirmative> only about six months out of having daily contact with the person I was taking care of you know, my ex. And he had moved on. And we were finally not running a business together. That was not healthy, that was not healthy, but Covid forced it on us at a very bad time.

(42:02):
So the heart attack for me, you know, that first day in cardiac rehab, like in my bed, I wasn't there very just a couple days, but all I did was of course, come to kind of try to come to grips with this. And I would agree that it is how I have found it has been a blessing in the long run because it forced me to take accounting of myself. It forced me to take care of myself. I mean, that's a choice. And I had been making a choice as to what I was doing all the years leading up acting like I had no choice. And in fact, a lot of my life I spent that way. I think growing up in a family that had in a lot of crises in it early on, you know, an alcoholic in parent really too is pretty disruptive. And I just got, since I was about five, I was the little caretaker, the little problem solver, the little crisis dealer with her. And this was just a screeching like, hit the wall, wake up call. I think that the slowing down I had to do, I absolutely had to do, I mean, I had months where I didn't make it through a day without an app. And I had to sort of manage the store

radically part-time and, and not be there while I was doing it. That really, it was necessity, but it was a gift.

Seán Collins (43:59):
I'm sensitive to you going through this without a caretaker at your sign. Mm-Hmm. <affirmative>, and I, I know that had to be hard,

Kris Kleindienst (44:09):
You know, it was such an odd thing because the end of my marriage was so traumatic and the caretaking that led up to it was, was so traumatic. And I was already pretty depressed. <Laugh>. I, I was definitely depressed. And I, I, I feel like I had already kind of had like a breakdown too two years before. And I spent a horrible time by myself in Covid. Like, COVID was like, pretty much the lockdown pretty much coincided with I am now alone. I did not see this coming. I did not want this. You know, I never imagined it and I have no, nothing left for myself because I gave it all to him to keep him alive. And I guess I'm a pretty scrappy type a person cuz I was just, by God, I'm going to go to France, you know, I'm gonna do something eventually here.

(45:37):
And when I had the heart attack and during the recovery process of the first many months, I, like you did not have that person. But what happened for me is that a few of my friends just wouldn't take no for an answer. I never knew how to ask for that kind of help. I never thought I could, I never thought actually I had friends who would do those things for me, and they did. They didn't even really, I got one person who lives in Pennsylvania just called me and she said, all right, who's making meals for you? I'm like, I'm okay. I got this. No, you don't. And she said, I'm gonna put this, I'm gonna build, make a thing. I'm gonna put it on Facebook. You'll get to approve people. I will, I will screen them and they're gonna sign up for meals because you can't do this. And she did. And they did. And I had like immediately a month of people coming out of the woodwork and cooking for me and doing other things for me. And she told me, she said, it is rude not to accept help when people offer <laugh>. So

Seán Collins (47:08):
That's because your name is cleanings. And she knew that the German guilt would work

Kris Kleindienst (47:12):
<Laugh>, she's right. I mean, you know, a little, I'm a a scrappy, hardworking peasant, right? <Laugh>, it's kind of a peasant name. And it was really a revelation and a learning process for, and it was, I had <laugh>. I feel like I had no choice, but I feel like I also can't say that I actually did choose to accept that help. Yeah. And it was the best thing I've ever done.

Seán Collins (47:43):
It's such a peculiar part of our culture that all of us who sort of strive for self-reliance and strength and self possession somehow, naturally think that that means we have to do this stuff alone. Not just that we're strong and have a role to play that's unique to our life, but that we have to do it alone in some way for it to be authentically us. So asking for help seems like one of the hardest things that Americans are asked to do.

Kris Kleindienst (48:21):
Yeah. And it comes, you know, I feel like men are by and large, the cruelty there is that they're supposed to be the tough person and emotions are still like, not allowed at all. And, and women are supposed to take care of everyone else. And it leaves both, you know, and everyone in between is some, you know, version of that. But it just, it's so sad. It's really sad

Seán Collins (49:01):
Because you learn, you learn so much in that vulnerable place of accepting home. Yes. You learn, you learn about friendship, you learn about where your limits are, like where, where your strengths are. Mm-Hmm. <affirmative>, you don't need help. And with

everything you need help with some things. And it's, I don't know, it's, it's, so it was sort of an experiment in self-discovery to accept that kind of help

Kris Kleindienst (49:32):
<Laugh>. It is, it, it, I'm so grateful for it. You know, the first, that first month I was too weak to really <affirmative> be anything but grateful. And, and you know, as time wore on, I realized I'd always thought, oh, I have to pay this person back. Now I have to cook for them, or I have to do something pretty much a tit for tat kind of construct. And as the year wore on and I just felt like my list of people I owed something to was getting longer, it made me uncomfortable. And then I realized it took me pretty much the whole year. So this is a recent realization. I gave myself permission to understand and accept that when people show a kindness, it's, it's not a bank loan. And people do acts of kindness that they are able to do and want to do. And the expectation is that they have helped the person, not that they will now, you know, be owed three meals and whatever, and that the best thing I can do is do my very best at taking care of myself and my health and to pay it forward. That the ways I can be kind in the world might not look like the ways they can be kind, but I can be kind. Yeah. And it's profoundly, I think it is profoundly the core of what makes us human. We need community, which was really challenged during Covid.

(51:44):
And I think the very basic, basic building block of community is kindness.

Seán Collins (51:54):
We've used metaphors about the heart. You mentioned Broken Heart earlier, and I, in the context of this sort of being kind and being open to offering people help and being open to receiving that help. I think about the, the phrase that we use, like opening your heart to people. It's another one of those heart metaphors of, of, we, we value that in principle, that openness of heart. But it's, it can tax us. It's, it's not necessarily easy, but it can become, as you say, a way of life that you having experienced this openness

of heart from others, that you might rededicate yourself to other ways that you can open yourself up to the world and how you experience it.

Kris Kleindienst (52:54):
Yes, yes.

Seán Collins (53:08):
Kris Kleindienst is the owner of Left Bank Books in St. Louis. My thanks again to Dr. Lori Tam, cardiologist at the Providence Heart Clinic, St. Vincent in Portland, Oregon. If you want to do more reading about women and heart disease, we have some links for you. Visit our website at Hear Me Now podcast.org. The Hear Me Now podcast is a production of the Providence Health System and its family of organizations. It's produced by Scott Acord and Melody Fawcett. We have research help from medical library staff, Carrie Grinstead, Basia Delawska-Elliot, Sarah Viscuso, and Heather Martin. Our theme music was written by Roger Neill. The executive producer is Michael Drummond. I'm Sean Collins. Thanks so much for listening. Be well.