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Maine Cardiovascular Health Council

A Coordinated Approach to CVD Risk Reduction

September is National Cholesterol Education Month

High blood cholesterol (HBC) increases the risk for heart disease, the leading cause of death in the United States. To reduce the prevalence of HBC in the United States, the National Heart, Lung, and Blood Institute initiated the National Cholesterol Education Program in 1985 and recommended that all adults aged >20 years have their cholesterol levels checked at least once every five years. One of the national health objectives for 2000 was to increase to 75% the proportion of adults aged >20 years screened for HBC during the preceding five years. This objective was revised for 2010 to recommend that 80% of adults in this age group be screened during the preceding five years. To monitor progress during the 1990s and to determine whether the 2000 objective was attained, data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) were used to examine the state-specific trends in cholesterol screening from 1991 through 1999. A recent MMWR report summarizes the results of this analysis and provides a projected estimate of the 2010 screening rates for HBC in each state. The findings indicate that few states attained the 2000 objective and that more emphasis on cholesterol screening will be needed to attain the 2010 objective.

Maine Cholesterol Screening
Percentage of Adults Who Have Had Their Cholesterol Checked in the Preceding Five Years

1991	1993	1995	1997	1999	Projected % for 2010
67.2%	69.1%	65.7%	71.7%	73.4%	77.6%

From: MMWR, August 25, 2000, Vol. 49, No. 33.

Inside This Issue:

Ideas for Promoting Cholesterol Education ... 2

Big Tobacco: A Powerful Enemy ... 2

AHA Simplifies Guidelines for CPR ... 3

SCORE-Keeper Software ... 3

How is Lower Socioeconomic Status a Risk Factor for CVD? ... 4

ME-Cares ... 5

CVD Summit ... 6

Workshop Announcement ... 6

Maine Governor's Council on Physical Fitness & Sports ... 7

Women & Heart Health Committee ... 8

Abstracts ... 9

Web Sites to Watch ... 10

Upcoming Events ... 10

Ideas for Promoting National Cholesterol Education Month (or for anytime)

Here are some ideas that you can adapt to fit the needs of your community.

- Coordinate with a grocery store and a local dietitian to give a grocery store tour demonstrating how to read food labels and choose heart-healthy foods.
- Decorate a bulletin board at the local community center with the theme, "Keep the Beat – Cholesterol Counts for Eveyone." Post cholesterol resources and educational flyers on the board.
- Work with local congregations to sponsor a cholesterol screening and health talk with a guest lecturer for community and church members.
- Feature Cholesterol Month at your weekly staff meetings for the month of September.
- Incorporate the cholesterol message into exercise classes and other events at your local health club.
- Hand out the "Check your Cholesterol and Heart Disease I.Q." test at the office, community meeting, or health club. (This test can be found online at www.nhlbi.nih.gov/health/public/heart/chol/chol_iq.htm)
- Write a news article with tips on how to reduce cholesterol through diet and exercise for people of all ages.

Big Tobacco: A Powerful Enemy

by Sarah Haggerty, Partnership for a Tobacco Free Maine, Maine Bureau of Health

Seven Maine people die from tobacco every day – one of them a non-smoker who dies from secondhand smoke. Tobacco disables and kills people through heart disease, stroke, numerous cancers, emphysema, diabetes, sudden infant death syndrome, and many childhood illnesses.

The tobacco industry spends $14 million marketing its products each day.

The Maine Bureau of Health has been allocated millions of dollars each year through the recent National tobacco settlement agreement (46 states). These allocations take Maine a giant step closer to winning the battle against tobacco, the state's number one cause of preventable disability and death.

The settlement agreement is based on recouping related illness costs from the Medicaid system. Through this agreement, Maine will receive a settlement payment of $47-$54 million per year. During the 2000 legislative session, $18.3 million was set aside to reduce tobacco use and tobacco-related illnesses.

Funds will be used to promote the goals of the Bureau's Partnership for a Tobacco-Free Maine (PTM). These goals include preventing tobacco use among youth, helping tobacco users quit, protecting the public from secondhand smoke, and eliminating health disparities. In addition, these funds will be used to reduce tobacco-related illnesses through the promotion of physical activity and healthy eating. Maine is already making important inroads in these areas. For example, since the 1997 tobacco excise tax increase and launch of the PTM, tobacco consumption (packs per capita) has decreased by 14%, triple the average rate of decline between 1988 and 1997.

Through financial settlements with Big Tobacco, Maine gains vital resources to battle this powerful, pervasive enemy.

AHA Simplifies Guidelines for CPR

Used effectively, cardiopulmonary resuscitation can save lives. Every year, five percent of people who go into sudden cardiac arrest outside a hospital owe their survival to the technique.

Now the American Heart Association is streamlining the process to make it even easier for people who have no medical training.

According to AHA president, Dr. Rose Marie Robertson, "225,000 people a year die because of an out-of-hospital arrest. If we could increase that (survival rate) by 20%, 50,000 more people could be saved."

Changes in CPR guidelines mean that people who have been trained to use the technique need to be recertified. Retraining is usually necessary every year in any case. New educational materials are now being distributed across the country.

Current guidelines, adopted in 1992, call for rescuers to follow the "ABCs" of CPR by checking the victim's airway, breathing, and circulation. If the airway is unblocked and the person still isn't breathing, CPR instruction then directs rescuers to check for a pulse. However, surveys have found that 35% of the time, they are wrong.

The new guidelines eliminate the pulse check and urge people to look for alternative signs that someone's heart is beating, such as normal breathing, coughing, and movement.

If no such signs are present, the guidelines instruct people to proceed to using chest compressions and rescue breathing in a ration of 15 compressions to two breaths. This should be repeated in succession at a rate of 100 compressions a minute, a change from the former rules, which called for a range of 80 to 100 compressions a minute.

Also changed are instructions on treating an unconscious choking victim. Instead of sweeping the mouth or using the Heimlick maneuver to dislodge a blockage, use only chest compressions, the Association recommended. This lessens the chance that any blockage will be depressed further into the airway.

It is important to note, however, that the first step remains to call a local emergency medical service or 911.

To find a CPR class near you, visit the American Heart Association's Emergency Cardiovascular Care Program site (www.proed.net/ecc/SEARCH_ECC.ASP) or call 1-877-AHA-4-CPR.

Cardiovascular Disease Prevention Software System Soon to be Available Through Western Maine Center for Heart Health

Burgess and Sandra Record announce that SCORE-Keeper, a comprehensive cardiovascular disease risk factor and behavior management software system, will be available very soon through Western Maine Center for Heart Health of Franklin Memorial Hospital in Farmington, Maine.

Twenty-five years of experience in managing successful community-based cardiovascular disease prevention interventions have gone into SCORE-Keeper. Developed specifically to serve the needs of community programs that provide behavioral and risk factor screening, counseling, referralal and follow-up, SCORE-Keeper helps shape, track, communicate, and evaluate both the process of care as well as behavioral and risk factor outcomes. Client-specific information gathered at any site – hospital, physician's office, school, worksite, and other community settings – is integrated, providing personal reports (ScoreCards) to individual clients and health care providers, as well as aggregate reports (ScoreSheets) to providers, employers, insurers, and managers, all with assured preservation of client confidentiality.

The web-based design of SCORE-Keeper will hopefully allow this service to be available and affordable to even the smallest community programs in Maine.

If interested in discussing SCORE-Keeper in more detail or arranging a free demonstration, please call 779-2701 or email slishern@fchn.org.

How is Lower Socioeconomic Status a Risk Factor for Cardiovascular Disease?

The interaction between tobacco addiction, poor nutrition, and physical inactivity, with the more general physical and social environments in which we live, makes it difficult to identify any one factor that is responsible for a person's death or disease. Individuals with less education and income tend to have more behavioral risk factors than those with more education and income. People living in less affluent communities tend to have higher burdens of cardiovascular disease regardless of their own education and income. The counties of Somerset, Aroostook, and Washington have the highest incidence in the state of CVD. Higher levels of social isolation in rural counties, long winters with fewer opportunities for people to walk, limited access to fresh vegetables and fruits, and reduced access to health care due to fewer resources for cardiovascular health all contribute to health status for low socioeconomic, rural populations in Maine.

Lower socioeconomic status (SES) is associated worldwide with premature morbidity and mortality. Several studies have indicated that although health behaviors at the individual level do play a role, they account for only about 13% of the excess mortality.[1] Additional factors exist that also have an impact. The three key factors are psychosocial, behavioral and biological.[2] How do clinicians deal with this information? More research needs to be done to understand why lower SES groups are more likely to have this constellation of risk factors – biological, behavioral and psychosocial – that increase their risk of mortality and the development of cardiovascular disease. The environment in which poorer people live has been suggested as a "source" of health damaging behavior. One study has shown that people who had been poor in childhood were more likely to engage in poor health behaviors as adults.[3] They were also more likely to have psychosocial risk factors such as hopelessness and hostility. In another study, parent-child communication patterns during the first three years of life were important. Welfare children heard fewer positive comments from their parents than children of working class and professional parents and this was correlated with school success years later.[4] Growing up in a harsh or less than optimum environment may teach children that the world is a hostile, depressing place and they might also learn that tobacco, alcohol and junk food help reduce the distress that such a belief might cause. Animal studies with monkeys have shown biobehavioral changes like reduced brain serotonergic function which could account for some clustering of health damaging behaviors.[5] The study animals were deprived of normal maternal care and so grew up to have reduced serotonin turnover as well as increased susceptibility to stress, increased alcohol preference, increased aggression, and decreased affiliative behaviors. A second study in rats showed that increased maternal attention in the first seven days resulted in animals that showed a smaller biologic response to stress and were less fearful.[6] There are a growing number of studies that have linked an absence of social support with all causes and cardiovascular disease mortality. The Almeda County study was one of the first to demonstrate that a lack of social integration, or participation in close social relationships, predicts mortality risk.[7] These studies deserve some thoughtful consideration of how similar conditions can affect future health and behavior.

A stronger association was found between income and health status than education and health status. Some influential factors are more prevalent among low income people and these might include less access to preventive care and health care services, more exposure to occupational/ environmental hazards, socioeconomic stratification and psychosocial variables such as lack of positive social networks, low self-esteem, chronic and acute stress including racism, classism and other factors related to the social distribution of power. So, health behaviors may be viewed to some extent as responses to or products of social environments (school, family, neighborhoods, worksites) rather than strictly individual behavior choices. In addition to broad population approaches, subgroups that are at especially high risk should also be targeted (women, ethnic groups, low SES).[2] In order to understand the special features of a high risk group that could affect program design, ethnographic research should be conducted to describe, compare, and target these groups with culturally specific interventions that address values, needs, and environmental influences. In addition, programs based on targeted subgroup approaches need to develop strong partnerships with communities and adapt strategies to the language and literacy needs, values and cultural systems of the population to be most effective.[8]

What can the health care provider do?

- ➢ Be aware of low SES and its potential impact on health and behavior.
- ➢ Recognize that there is not one approach needed—both individual and societal approaches are needed.
- ➢ Provide or refer to screening and counseling services
- ➢ Think prevention - continue to encourage healthy behaviors especially good nutrition, physical activity, tobacco cessation, and stress reduction for all populations, not just those you think will listen.
- ➢ Encourage positive family and social interactions, good parenting skills, communication skills, and competency building training for both children and adults.
- ➢ Promote social environment policies that support health throughout the community – lend your voice to the development of credible policies that offer support for healthy behaviors.
- ➢ Become familiar with free and low cost resources that your population can access.

Additional Resources:

- Maine Bureau of Health – www.state.me.us
- Network on Socioeconomic Status and Health, MacArthur Foundation's Program on Human and Community Development – www.macfdn.org
- Centers for Disease Control & Prevention – www.cdc.gov
- American Heart Association – www.americanheart.org

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ME-Cares -- Nurse-Physician Care Support

ME-Cares, the task force to develop nurse physician care support systems to address secondary prevention of cardiovascular disease, has implemented the program in 17 hospitals from Biddeford to Fort Kent. A plan for collecting a minimum and standardized data set from each hospital has been defined. Nurse training and support has been provided through an intensive three-day educational session. Site visits for one-on-one contact, monthly conference calls, and a monthly newsletter with up-to-date information on care management issues has been distributed. Physicians from each of the institutions have received an orientation and are beginning to make patient referrals. A credentialing plan, together with an evaluation framework, have been developed. Four additional hospitals with possible affiliates are negotiating the program at this time, with continual outreach to remaining hospitals in the state. In addition, the clinical office systems component of the Partnership for a Heart-Healthy Maine project will work with physician offices to develop a prevention system. For more information, please contact Vickie Rea, CVD Prevention Coordinator, vrea@mcd.org or 207-622-7566, ext. 214.

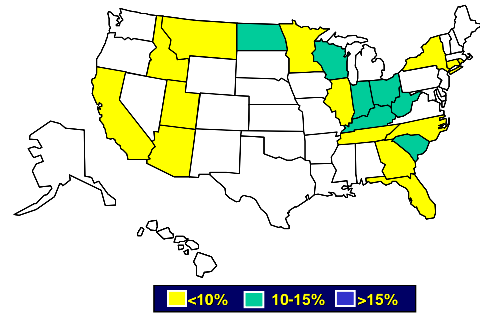
Fourth Governor's Cardiovascular Health Summit Held at Bowdoin College on June 22nd

"The function of protecting and developing health must rank even above that of restoring it when it is impaired." - Hippocrates

The annual Governor's Cardiovascular Health Summit seeks to bring together those interested in cardiovascular health promotion and disease prevention to review programs and progress and suggest a direction for Maine. This year marked the fourth annual Summit and over 150 participants focused on challenges in the 21st century for cardiovascular health. The keynote speaker was James Marks, MD, Director of the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention in Atlanta. Dr. Marks provided an overview of the recent trends in cardiovascular disease and stroke. He provided information about the dominant behavioral risk indicators and their relationship to heart disease, especially tobacco use, the obesity epidemic in the U.S., and the benefits of physical activity in preventing disease. In addition, he highlighted the importance of adverse childhood experiences, socioeconomics, and depression as having an impact on chronic disease. Following the keynote address, a "town meeting" was held to provide participants the opportunity to discuss issues in an open forum. Later in the day, model programs and workshops focused on what the community, worksite, schools, and health system can do to help prevent cardiovascular disease.

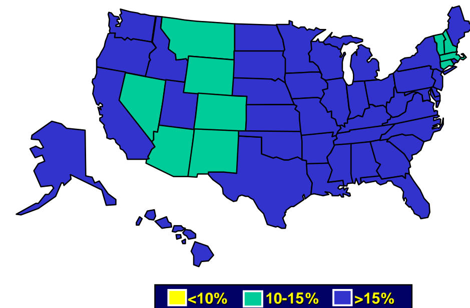
John LaCasse, president of Medical Care Development, received the Larry Johnson award for his outstanding contribution to cardiovascular health in Maine.

Prevalence of Overweight among U.S. Adults, BRFSS, 1985



Source: Mokdad, et al.

Prevalence of Overweight among U.S. Adults, BRFSS, 1998



Source: Mokdad, AH, et al. J Am Med Assoc 1999;282:16.

Screening Workshops to be Held in Auburn

Cholesterol and Blood Pressure screening workshops will be offered November 14th & 15th at Knucklehead's Restaurant andConference Center in Auburn. Each full day workshop focuses on the latest information and hands on training for screening for these risk indicators. Dr. Burgess Record of the Western Maine Center for Heart Health in Farmington and Dr. Leonard Kielson, Director of the Lipids Center at Maine Medical Center will provide an overview of cholesterol during the morning of November 14th. In the afternoon, Wendie Lagasse, Director of the Community Health Center at Eastern Maine Medical Center, offers hands on training in testing for blood cholesterol and Sue Grondin of the State Laboratory will provide an overview of state and federal requirements.

On Wednesday, November 15th, Annie O'Shea, RN, MPH, will offer a blood pressure measurement and equipment calibration workshop based on the recommendations from the JNC 6 guidelines (1997). For more information, please visit the MCHC web site at www.mainecardiohealth.org or contact Diane Campbell, 622-7566, ext. 230, or dianec@mcd.org.

Did You Know...

Counseling about Exercise

Fewer than half of obese patients report being counseled by a health professional about weight loss and only one third of a national sample report being counseled about exercise. Physicians were more likely to counsel as secondary prevention with older patients, less likely to counsel about the risk of obesity, and tend not to counsel younger adults and those from low SES populations about the importance of physical activity and health. JAMA, October 27, 1999-Vol.282, No. 16, p 1583.

Don't forget your flu shot

An annual flu shot can reduce risk of heart attack. A five-month study of more than 200 cardiac patients found that those who had been given flu shots had a 67% lower risk of suffering a second heart attack than those who had not been given flu shots. Flu vaccination may prevent infections that can inflame obstructions in the arteries. Look for more on this study in an upcoming issue in the journal Circulation.

The Maine Governor's Council on Physical Fitness & Sports Activities

The Governor's Council on Physical Fitness and Sports continues to be active promoting the benefits of physical activity throughout the state of Maine. A Contest for Communities physical activity celebration was held on May 9th at the Blaine House in coordination with WGBH Channel 6 for media promotion of physical activity. The following received awards:

- Seung Choi - Choi School of Self Defense
- Abe Furth & Rahvi Barnum - Pedaling to Prevent Violence
- Portland Public Health - March into May Greater Portland
- Osteoporosis Health Network - 1st Annual Bone Density Dash
- Fit for Fall - Hannaford Wellness Program
- The South Bristol Spindrifters (jump rope artists)
- The Gym Dandies Children's Circus of Scarborough (unicycle & juggling)
- Wellness, Inc. - Rumford
- Health & Fitness with Skiing - Stockholm Elementary School
- Community Health & Counseling Services - Bangor (physical activity & mental health)
- Windham Schools & St. Joseph College (children/young adults with special needs)

The Council formed a partnership with the University of Southern Maine to co-sponsor the Maine Girls and Women in Sports Awards held again this year in February. The 2000 celebration saw over 4000 participants in 73 events around the state culminating in an awards banquet held at the Holiday Inn by the Bay in Portland. Patsy Wiggens from Channel 13 was the emcee.

The 2000 winners were:

Exemplary High School Female Athletes - Christie Bisco, Windham High School and Jillian LeClair, Gardiner Area High School

Exemplary College Female Athlete - Penny Osbourne, University of Southern Maine

Exemplary Professional - Anne Beaney, Scarborough

Exemplary Lifetime Commitment - Terri Regan, Wells

ACES (All Children Exercising Simultaneously) was held on May 3rd with approximately 6,000 participants in schools and day care across the state. For information about ACES 2001, please contact the Governor's Council at 207-622-7566, ext. 230.

New Committee on Women & Heart Health

The Maine Cardiovascular Health Council in collaboration with the Women's Health Campaign, has formed a committee to develop a planning approach to women's heart health in Maine. Members of the committee include the following:

- Saskia Bopp, Maine Cardiovascular Health Council
- Erin Cheever, Portland Public Health
- Steve Frost, MaineGeneral Medical Center
- Brenda Glasgow, Community Health Services
- Paul Hammond, American Heart Association
- Barbara Leonard, Maine Bureau of Health
- Dervilla McCann, MD, Androscoggin Cardiology Associates
- Lisa Miller, The Bingham Program
- Cathy Morrow, MD, Maine Dartmouth Family Practice Residency
- Donna Polk, MD, Maine Medical Center
- Vickie Rea, Medical Care Development
- Laura Ronan, MPH, Medical Care Development
- Brenda Sexton, MD, Yarmouth
- Meredith Tipton, Anthem Blue Cross and Blue Shield
- Karen Umphrey, Aroostook Medical Center
- Dennise Whitley, American Heart Association, N.E. Affiliate
- Debra Wigand, Maine Bureau of Health

For more information, please contact Vickie Rea at vrea@mcd.org or 207-622-7566, ext. 214.

We invite you to take a look at the report, **Women and Heart Disease - A Study of Women's Awareness of Attitudes Towards Heart Disease and Stroke** prepared by Yankelovich Partners Inc., in August, 1997 and available at www.americanheart.org.

KEY FINDINGS

- Most women do not recognize heart disease as a leading health problem and cause of death of women today. When asked on an unaided basis, cancer is identified by more than half as both the one greatest health problem facing women and the leading cause of death.
- When asked directly in a true/false context, nearly half agree that heart disease is the leading cause of death in women.
- Despite the low levels of awareness surrounding heart disease, many women still worry about getting heart disease, heart attack, or stroke. More women, however, worry about cancer than heart disease.
- More than seven in ten women (73%) recall hearing, seeing, or reading information on heart disease in the last 12 months. However, only one-third (34%) consider themselves well informed about heart disease and even fewer (28%) about stroke/brain attacks.
  - Awareness of heart disease communications varies somewhat with age and ethnicity.
  - Hispanic women and younger women have significantly lower awareness levels.
- Print media, particularly magazines, are cited most frequently as sources of information on heart disease.
- Although most women (91%) are receptive to talking about health prevention and treatment options with their doctors, few of their doctors (30%) have discussed heart disease when discussing their health.
- Doctors are significantly less likely to speak about heart disease to women younger than 35 than to those 35 and older.
- Most women do understand that heart attack or strokes can result in a long-term illness and not sudden death. However, one out of three women (36%) still incorrectly associate heart disease with sudden death and do not associate stroke with being a long-term, debilitating disease.
- In general, women believe that they are most likely to develop heart disease in middle age, particularly between 50 and 69 years old.
- In a series of true/false questions, most women reveal they know that heart disease develops gradually and can go undetected (91%), and that some forms of heart disease may result in a stroke (87%).
- Over half of all women misunderstand the differences between men and women having heart disease, generally assuming that men are at greater risk.

- ❤ Most women realize that there are things they could do to prevent heart disease, including altering dietary and exercise habits, and stopping unhealthy behavior, such as drinking and smoking.
- ❤ Over half of all women (56%) agree that taking estrogen replacement therapy can help reduce their risk of heart disease.
- ❤ On an unaided basis, women identify a number of key factors as major causes of heart disease, including being overweight, smoking, not exercising, and high cholesterol. However, no one cause was mentioned by more than one in three women.
- ❤ On an aided basis, 90% of women correctly identified seven activities that can prevent or reduce the risk of getting heart disease.
- ❤ Six in ten cite taking special vitamins like E, C, or A as a preventive measure.
- ❤ Many women report taking recent medical tests that would reveal incidence of heart disease — 93% report having their blood pressure checked and 61% have had their cholesterol level checked.
- ❤ More women can identify the warning signs of a heart attack than those of a stroke/brain attack.
- ❤ The majority of women report that they would call 911 or an ambulance if they were having a heart attack or stroke.

Abstracts

Gender, age may affect treatment for hypertension, new study suggests

(7/18/00 HeartInfo) New research suggests that gender and age may affect the way people respond to treatment for high blood pressure. For instance, aggressive antihypertensive treatment with the long-acting calcium antagonist Felodipine may be more effective and more tolerable in older people than in their younger counterparts, suggests a new analysis of the Hypertension Optimal Treatment (HOT) study. Study authors aimed to "assess the influence of gender and age on the main outcome results of the HOT study." (Journal of Hypertension/MedscapeWire, May 22, 2000)

The Truth About Vitamin E

The latest research suggests those little golden capsules may not stave off heart disease after all. Does that mean you should not be taking them?

In a January 20, 2000 issues of the *New England Journal of Medicine,* the golden pill, Vitamin E, may not live up to its promise. Canadian researchers tracked 2,545 women and 6,996 men aged 55 or older who took either Vitamin E or a dummy pill. After five years, those taking the vitamin were no better off than those taking the dummy pill, suffering just as many heart attacks, strokes, and deaths from cardiovascular disease. The findings are part of a study called HOPE, or the Heart Outcomes Prevention Evaluation.

However, other evidence suggests the antioxidant property of Vitamin E has other benefits such as boosting immune system function and possibly delaying Alzheimer's disease. (The article is available online at www.webMD.com)

New CAD Risk Factors: Interesting, but How Useful?

The prevention of coronary artery disease (CAD) is a major focus of cardiovascular research, and the search for modifiable risk factors has progressed considerably during the past five years. A high blood homocysteine level, for example, has been identified as an important determinant of CAD risk. Other tantalizing leads include associations between CAD and depression, infectious agents, fibrionogen, C-reactive protein, triglycerides, small low-density lipoprotein (LDL) cholesterol particles, and lipoprotein (a). (article by Mary Pinkowish, Medical Economics Publishing, Patient Care, June 1998; 32(11).)

Factoids

- Tobacco cultivation occupies up to 72% of arable land in some developing countries. Zimbabwe derives most of its foreign exchange from this source.
- Cigarette consumption in Africa has increased by over 40% in the past two decades.
- Cardiovascular disease death rates have risen by 40% in Hungary and the former Czechoslovakie, by almost 60% in Poland, and by almost 80% in Bulgaria. These rates reflect massive increases in adult male mortality.

Web Sites to Watch

www.infonet.st-johns.nf.ca/providers/nhhp/ for Heart Matters, a newsletter for the community.

www.women.americanheart.org - The American Heart Association's Women's website gives women of all ages everywhere the facts on women's heart disease and stroke.

www.heartpoint.com a source of credible information about heart disease created by medical professionals.

www.nhlbi.nih.gov - Your guide to understanding high blood pressure.

And don't forget www.mainecardiohealth.org - the website of the Maine Cardiovascular Health Council. Check it out for the latest news and events.

Upcoming Events

October 11 and 12, 2000 - Blaine House Summit on a Healthy Maine, Augusta Civic Center. If you have not received a brochure or are looking for further information, contact Sue-ann Sanford at 207-622-7566, ext. 232.

October 27-20, 2000 - Youth Summit 2000, Sugarloaf, USA. Sponsored by the Partnership for a Tobacco-Free Maine, Maine Bureau of Health. For further information contact Ann Conway at 207-622-7566, ext. 246, or Kevin Brady at ext. 254.

October 30, 2000 - Maine Public Health Association's Annual Meeting, Eastland Parkside Hotel, Portland. The topic this year is *Working Together Towards a Healthy Maine 2010.* For further information on this conference check out www.mcph.org/mpha/MPHAevents.html or call Diane Campbell at 207-622-7566, ext. 230, for a brochure.

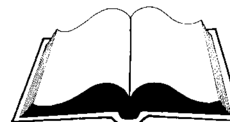
November 12-16, 2000 - American Public Health Association Annual Meeting & Exposition, Boston, Massachusetts. For more information check out their website at www.apha.org

Triglycerides Revisited

Though doctors have long suspected that blood fats known as triglycerides contribute to heart disease, clinical studies have not yet established that elevated triglyceride levels constitute a risk factor for cardiovascular disease. Now, a study in the June 20 *Circulation* finds that high triglyceride levels significantly increase the risk of dying from heart disease -- even among people with normal cholesterol levels. **These findings suggest that measuring and monitoring triglycerides may eventually play a role in evaluating cariovascular health.** (From *Circulation 2000;* 101:2777)

Resource Directory Update

The Directory of Cardiovascular Risk Reduction Activities, a compilation of cardiovascular risk prevention services that are provided by Maine hospitals, home health agencies, and community coalitions will be available online at the Maine Cardiovascular Health Council's webpage (www.mainecardiohealth.org/resources/default/htm) beginning October 5, 2000. This updated online version will allow you to search by county, type of facility, and type of service you are looking for.



Editorial Policy: The MCHC welcomes articles concerning cardiovascular disease for submission to the newsletter. ALL submissions should be submitted on a computer disk (in Microsoft WORD, if possible) or typed and double-spaced, with the author's name and address. The editorial staff reserves the right to determine acceptance for publication. The information contained herein has been obtained from sources believed to be reliable and the editors have exercised care to assure its accuracy. However, the MCHC does not guarantee that the contents of this publication are correct or necessarily reflect on the views or policies of the Council, nor does the mention of trade names, commercial products, or organizations imply endorsements by the Council.
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