HIDDEN HEART HEALTH RISKS EVERY WOMAN SHOULD KNOW

Your periods, pregnancies and menopause may reveal important clues about future cardiovascular risk. Understand your history, know your numbers and prepare for your next check-up.

A note from Dr Lucy Hooper

I'm Dr Lucy Hooper. I've been a doctor for over 20 years and specialise in prevention. One thing I find frustrating about women's heart health is how often the clues have been there for decades, but nobody has joined the dots.

This is personal to me. I've experienced PCOS, early menopause and raised lipoprotein(a). I've had to consider my own lifetime cardiovascular risk, both as a physician and as a woman.

THE GOOD NEWS

Cardiovascular disease is the leading cause of death among women worldwide. In the UK, coronary heart disease kills twice as many women as breast cancer, according to the British Heart Foundation. Yet an estimated 80% of premature cardiovascular deaths may be preventable. This is absolutely a women's health problem, but one where we can do so much to reduce risk.

What is this guide for?

This guide draws on current research and guidance, including the European Society of Cardiology. It does not replace a consultation with your own doctor. I hope it helps you prepare for an appointment or health check, ask better questions and get more from the conversation.

Some tests described here are not routinely available on the NHS, although many important checks are part of preventive care, including the NHS Health Check for eligible adults in England.

A NOTE ON GUIDELINES

I often refer to European Society of Cardiology guidance in preference to UK NICE guidance as they take a more proactive approach to risk and prevention in my opinion. Recommendations still need to be tailored to the individual.

DR LUCY HOOPER | MBBS BSc MA MRCGP DRCOG DCH

Physician, Co-Founder & Medical Director, Coyne Medical

Your hormones, your history, your heart

From periods to pregnancy and menopause, reproductive history can affect cardiovascular risk. Has your doctor ever asked?

PCOS has a new name: PMOS

In May 2026, polycystic ovary syndrome (PCOS) was renamed polyendocrine metabolic ovarian syndrome (PMOS). The new name recognises that this is not just about ovaries, periods or fertility. PMOS is associated with insulin resistance, diabetes, adverse cholesterol profiles and sometimes raised blood pressure. Its independent effect on cardiovascular events is still being studied.

IF YOU HAVE PMOS (PREVIOUSLY PCOS)

Ask for a review of your blood pressure, cholesterol and blood glucose or HbA1c, even if you are young, slim and feel well.

Pregnancy is a cardiovascular stress test

Pre-eclampsia, high blood pressure during pregnancy, gestational diabetes, preterm birth, stillbirth or a baby small for gestational age may signal increased risk many years later. Tell your doctor even if everything returned to normal after delivery.

After pre-eclampsia or pregnancy hypertension, keep checking your blood pressure throughout life. Home readings can uncover hypertension that might otherwise go unrecognised. In one study after pre-eclampsia or HELLP syndrome, new hypertension was identified in 34% using home monitoring versus 11% with usual care over a year.

Coyne Medical: how to check blood pressure at home >

Menopause is a time to reassess

As oestrogen declines, LDL cholesterol and ApoB may rise, with changes in abdominal fat and insulin sensitivity. Even Lp(a), which is largely inherited, may shift around menopause in some women, although studies are mixed. Menopause before 45, especially before 40, is an additional important risk clue.

MORE THAN HRT

Good menopause care should include cardiovascular and cancer risk assessment, bone health and prevention alongside symptom management. HRT can help symptoms but is not prescribed solely to prevent cardiovascular disease.

Could your risk be higher?

Tick anything relevant and take it to your doctor. European Society of Cardiology risk modifiers help refine risk estimates, especially near treatment thresholds.

FEMALE-SPECIFIC HISTORY

- [ ] Pre-eclampsia / high BP in pregnancy
- [ ] Premature menopause (especially before 40)
- [ ] PMOS / PCOS (additional metabolic clue)
- [ ] Gestational diabetes or other adverse pregnancy outcomes

FAMILY AND PERSONAL BACKGROUND

- [ ] Early CVD in male relative under 55 or female relative under 60
- [ ] South Asian / other higher-risk ancestry
- [ ] Social deprivation or barriers to care
- [ ] Psychological stress / stress symptoms

INFLAMMATION AND DISEASE

- [ ] Chronic immune-mediated / inflammatory disease
- [ ] Major psychiatric disorder
- [ ] HIV infection
- [ ] Obstructive sleep apnoea

PHYSICAL AND METABOLIC FACTORS

- [ ] Obesity
- [ ] Physical inactivity
- [ ] Raised Lp(a) above 50 mg/dL or 105 nmol/L
- [ ] Persistently raised hsCRP above 2 mg/L

ESTABLISHED RISK AND CONDITIONS

- [ ] High blood pressure
- [ ] High LDL cholesterol / ApoB or familial hypercholesterolaemia
- [ ] Diabetes
- [ ] Current smoking
- [ ] Chronic kidney disease
- [ ] Known cardiovascular disease or plaque on imaging

USEFUL ADDITIONAL HISTORY

- [ ] Strong family history of diabetes
- [ ] Prior cancer therapy with potential cardiac effects

WHY THIS MATTERS

The 2025 European Society of Cardiology update highlights 12 demographic/clinical modifiers and two biomarkers; all are included above. PMOS, gestational diabetes and the established risks are added because they are also important in a complete assessment. A tick does not diagnose heart disease.

European Society of Cardiology / EAS 2025 risk modifier guidance >

Know your numbers

Your personal goal depends on your overall risk. Some important risk factors cause no symptoms.

LDL CHOLESTEROL

Below 3.0 mmol/L

A general goal for healthy adults at low cardiovascular risk. Other risk factors or medical history may mean a lower target is recommended.

Lower ESC/EAS LDL goals for greater risk:

<2.6	<1.8	<1.4
MODERATE RISK	HIGH RISK	VERY HIGH RISK

These LDL goals come from ESC/EAS guidance, retained in the 2025 update. High- and very-high-risk treatment generally also aims for at least a 50% fall from untreated LDL. Goals are not automatic thresholds for medication.

BLOOD PRESSURE (mmHg)

<120/70 mmHg

Optimal office or in-clinic BP for most adults. If blood pressure is persistently low or causes symptoms, review with your doctor.

>=135/85 mmHg

A home average with systolic >=135 and/or diastolic >=85 mmHg suggests hypertension. Arrange medical assessment.

If treated for high blood pressure, the 2024 European Society of Cardiology guidance generally aims for systolic 120-129 mmHg if tolerated. Your doctor may individualise this, particularly with frailty or dizziness. Use repeated, correctly taken readings.

OTHER USEFUL NUMBERS

HbA1c	**<42 mmol/mol**	42-47 indicates increased diabetes risk; 48 or above may indicate diabetes.
Waist / height	**<0.5**	Keep waist circumference below half of height.
Lp(a)	**>105 nmol/L**	Above this, or 50 mg/dL, risk may be higher. Not a treatment target.
ApoB	**Risk-based**	An extra particle measure; your individual target depends on overall risk.

More tests are not always better

Many are not routinely available in UK NHS care. Choose someone who can guide you through deciding which tests matter, interpreting results and planning next steps.

ApoB: cholesterol particle number

ApoB counts potentially plaque-forming lipid particles. It may tell a different story from LDL cholesterol: some people have more particles than their LDL-C suggests, others fewer. This discordance may affect how intensively LDL should be treated.

Lp(a): an inherited clue

Around one in five people have a high Lp(a). It is worth checking at least once in adulthood to refine overall cardiovascular risk. Because it is largely genetic, it usually does not need routine repeat testing.

hsCRP: inflammation and residual risk

Particularly useful when cardiovascular risk is already elevated. Persistent inflammation may signal residual risk even with well-controlled LDL. A raised result needs review for other causes, repeat testing where appropriate and a clear follow-up plan.

Coronary artery calcium: not the whole picture

Very popular in the US. CAC is most useful when risk or the decision to start a statin is uncertain. Younger people and women can have a zero score but still have non-calcified plaque. A zero is reassuring in context, not a guarantee.

VO2max: useful, but not a competition

A favourite of longevity influencers, and with good reason: fitness strongly predicts long-term mortality. Watches can estimate it; formal testing measures it more directly. But it does not replace BP, lipids or glucose checks. Being regularly active helps reduce cardiovascular and some cancer risks whatever your score. Gold medals are not required.

THE VALUE IS IN THE NEXT STEP

Testing without interpretation can leave you with data and no plan. The most useful test is one that helps you and your clinician make a better decision.

Protect your heart

Small, specific habits matter. You do not need to be perfect or to join a gym to make progress.

FIVE THINGS THAT PAY OFF

1. Move for at least 150 minutes a week.

Aim for moderate-intensity activity, such as brisk walking, cycling or active gardening, plus strength work twice weekly. It need not be a gym workout.

2. If you smoke, stop.

For someone who smokes, quitting is one of the highest-impact health decisions you can make. Ask for help if you need it.

3. Know and act on your numbers.

Even increases that seem modest can matter. In large observational studies, each 20 mmHg higher systolic blood pressure was associated with about twice the risk of fatal coronary disease.

4. Eat to protect your arteries.

Choose vegetables, pulses, wholegrains, nuts and olive oil; include fibre and minimise excess salt.

5. Treat risks when needed.

Regularly review blood pressure, cholesterol and diabetes risk. Medication can be an important part of prevention alongside lifestyle.

SYMPTOMS: ADVOCATE FOR YOURSELF OR SOMEONE YOU LOVE

Chest pressure, tightness or discomfort is common in women as well as men. Breathlessness, nausea, sweating, arm, back, neck or jaw pain, lightheadedness or marked fatigue can also occur. Women with heart attacks often reach hospital later and face higher risks of missed diagnosis and poorer outcomes. Do not dismiss symptoms as anxiety, indigestion or being unfit. It is better to be assessed and reassured than miss the chance for timely treatment.

POSSIBLE HEART ATTACK? CALL 999

If you suspect a heart attack, call 999 immediately, even if the symptoms come and go. Do not drive yourself to hospital or wait for a routine appointment.

NHS: symptoms and emergency advice >

AND FOR THE MEN IN YOUR LIFE

Many of the risk factors in this guide apply just as much to men, including raised blood pressure, LDL cholesterol, Lp(a), diabetes, smoking, family history and lack of exercise. In fact, men generally develop cardiovascular disease earlier than women and tend to have a higher risk at younger ages. Knowing these numbers and acting on them early is especially important for men too. Encourage the men in your life to have their own cardiovascular risk reviewed rather than waiting for symptoms.

My heart health plan

Bring this page to your doctor. Record both your result and the target that is right for you.

MEASURE	MY RESULT	MY TARGET
Home blood pressure (mmHg)		
LDL cholesterol (mmol/L)		
ApoB (g/L)		
Lp(a) (nmol/L or mg/dL)		
HbA1c (mmol/mol)		
Waist-to-height ratio		

QUESTIONS TO ASK

- [ ] Have we included pregnancy, PMOS, menopause and family history?
- [ ] What are my 10-year and lifetime cardiovascular risks?
- [ ] What should my LDL and BP targets be?
- [ ] Would ApoB, Lp(a) or another test change my plan?
- [ ] What should I do now, and when should we review?

My main worry: _____

My next action: _____

My review date: _____

WANT TO DISCUSS YOUR PERSONAL RISK?

GP consultations >

Review an abnormal blood test or Lp(a) result, discuss your blood pressure, hormones or concerns, and agree the next steps with a doctor.

Doctor-led health screening >

From detailed annual checks, including cervical screening or PSA where appropriate, to Ultimate with inherited cancer genetics, pharmacogenomics and whole-body MRI.

contact@coynemedical.com | +44 20 7731 3077

Written by Dr Lucy Hooper | MBBS BSc MA MRCGP DRCOG DCH | 10 November 2026

For educational purposes. This guide is written by a practising physician to inform and help you prepare for a consultation. It is not medical advice and does not replace assessment by your own doctor. Clinical guidance: Coyne Medical is an independent private clinic. Our approach draws on current evidence and is tailored to the individual; recommendations may differ from NHS/NICE pathways, which also consider resources and population-level care.