Preface

Not a 70-Kilogram Man

Melissa McNeil, MD, MPH, MACP
Editor

The explosion of information about gender-specific conditions in the last two decades highlights the need for providers with an interest and knowledge about conditions unique to women (eg, menopause), more common in women (eg, osteoporosis), or which present differently in women (eg, cardiovascular disease). One has only to look at the changing views regarding hormone therapy (HT) to understand the need for up-to-date practitioners. In 1995, HT was thought to be beneficial for both primary and secondary cardiac prevention, to be effective in reducing osteoporotic fractures, and to pose no increased risk for breast cancer or thromboembolic events. Beginning with the early release of the Women's Health Initiative results in 2001, these views have radically changed. We now would not use HT for either primary or secondary prevention of cardiac disease, and we appreciate increased risks of both breast cancer and thrombosis. The only "medical certainty" still standing is the belief that HT reduces osteoporotic fractures. However, the advent of new therapies, such as bisphosphonates and selective estrogen receptor modulators, has made even osteoporosis prevention a dubious indication for HT as a first-line treatment for osteoporosis.

A knowledge of the differences in disease presentation and treatment in women is crucial to any provider with a desire to provide comprehensive, evidence-based care for women. This issue of the *Medical Clinics of North America* focusing on Women's Health seeks to highlight those conditions that have gendered differences in diagnosis and treatment, including conditions wherein biologic sex and gender preference are different. For many years, women have either received fragmented care with "gendered conditions" being managed only by our gynecologist colleagues and with little appreciation of how these conditions impact the overall health of women. It is very hard to imagine, for example, how a primary provider of women could manage breast health, bone health, and heart health without understanding the impact of menopause and reproductive hormones on all of these conditions. There are new data that suggest that a woman's reproductive history impacts her subsequent risk

Med Clin N Am 107 (2023) xvii–xviii
https://doi.org/10.1016/j.mcna.2022.10.015
0025-7125/23/

of cardiovascular disease. Preeclampsia, gestational hypertension, and gestational diabetes (just to name a few) all are risk factors for early cardiovascular disease in women and should be factored into risk assessment by providers. Increasingly, with cervical cancer screening becoming less frequent, women see gynecologists with less regularity, and thus, primary providers need to be aware of signs of symptoms of gynecologic malignancies, such as postmenopausal bleeding and abdominal bloating. A thorough understanding of all of these conditions and more is crucial to providing exceptional gender-specific care to the women we serve.

It is my hope that this issue of the *Medical Clinics of North America* will highlight these important gender-specific conditions, their diagnosis, and their treatment. The goal is to provide a roadmap to comprehensive care for women with specific recommendations and management strategies provided so that a provider, after reading this issue, will have the knowledge and skills necessary to view women as unique, complex, and endlessly interesting patients! The fragmentation of care for women has not served our patients well, and this is one attempt to end the "patchwork quilt" of care that women have so often experienced and to empower us as providers to see our women patients as more than just 70-kilogram men!

Melissa McNeil, MD, MPH, MACP
Warren Alpert School of Medicine of Brown University
Rhode Island Hospital
Women's Health, VHA Central Office
593 Eddy Street, Suite JB0105
Providence, RI 02903, USA

E-mail address:
mmcneil4@lifespan.org